

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12934

12949

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 34 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 313 Nottingham Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARGARET Middle NMN Last ANTHONY		4. DATE OF DEATH Month Dec. Day 16 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1888
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Frederick County, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Bageant		14. MOTHER'S MAIDEN NAME Sarah Morland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Russell J. Weaver		313 Nottingham Road Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes mellitus DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 3 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 13 , 19 56 , to Dec , 19 56 , that I last saw the deceased alive on 12/16/56 , 19 56 , and that death occurred at 1:00 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE E. L. Houchlander M.D.		ADDRESS (Street, city or town, state) Hagerstown Md.	
DATE SIGNED 12/17/56			
PHYSICIAN'S NAME (Type) E. L. Houchlander		Eldon G. Hoachlander M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 18, 1956	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		ADDRESS Wm. C. Harsh U. Pres.	
24a. REC'D BY REGISTRAR Dec. 18, 1956		24b. REGISTRAR'S SIGNATURE Wm. C. Harsh	

7. 2000

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12935

13006

CERTIFICATE OF DEATH

Reg. Dist. No.

305

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MONROE - RURAL</u>				c. LENGTH OF STAY IN 1b <u>10 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOONSBORO MD. R. 1</u>				d. STREET ADDRESS <u>BOONSBORO MD. R. 1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE R. BAKER</u>				4. DATE OF DEATH Month Day Year <u>DECEMBER - 30, 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER - 4 - 1878</u>	
9. AGE (In years lost birthday) <u>78 - 1 - 26</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>EAST BERLIN PENNA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JACOB M. BAKER</u>				14. MOTHER'S MAIDEN NAME <u>MARY MUMMERT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-14-6218</u>		17. INFORMANT Address <u>MRS. MARY R. BAKER BOONSBORO MD. R. 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the right lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DUE TO</u> (c) <u>DUE TO</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 1, 1956</u> , to <u>Dec. 30, 1956</u> , that I last saw the deceased alive on <u>Dec. 29, 1956</u> , and that death occurred at <u>1 - 4 - M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter H. Shealy</u> M.D.				ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u> DATE SIGNED <u>12/31/56</u>			
PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MANOR CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NR. TILGHMANTON WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>BAST FUNERAL HOME BOONSBORO MD.</u>				24a. REC'D BY REGISTRAR <u>JAN. 2, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Post</u>	

BUREAU V.

1967 2 Nov

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12936

13007

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SAN MAR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> <u>03</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRNEY-KEEDY MEMORIAL HOME</u>		d. STREET ADDRESS <u>626 N. MULBERRY ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LYDIA - VIRGINIA BAKER</u>		4. DATE OF DEATH Month Day Year <u>DECEMBER - 16 - 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST - 26 - 1872</u>
9. AGE (In years lost birthday) <u>84-3-20</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL RICHARDS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH FASIVACHT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>GEORGE E. RICHARDS</u>		Address <u>626 N. MULBERRY ST. HAGERSTOWN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary arteriosclerosis</u> <u>447X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with hypertension</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 10, 1956</u> to <u>Dec. 16, 1956</u> , that I last saw the deceased alive on <u>Dec. 16, 1956</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. LeVan</u>		ADDRESS (Street, city or town, state) <u>Boonsboro Md.</u>	
PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>		DATE SIGNED <u>12/17/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>DEC. 19, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MANOR CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>NR. TILGHAMANTON MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>		ADDRESS <u>BOONSBORO MD.</u>	
24a. REC'D BY REGISTRAR <u>John R. Bass</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>Dec 18, 1956</u>			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The text is faint and mostly illegible.

BUREAU V. S.

DEC 21 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12937
303

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Enroute to Washington County Hospital		e. STREET ADDRESS RFD #5	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle William Last Barthlow		4. DATE OF DEATH Month Dec. Day 6 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1891
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 6 Days 19 Hours 56	11. IF UNDER 24 HRS. Months 6 Days 19 Hours 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY farms	
11. BIRTHPLACE (State or foreign country) Berkeley Co., W. Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Eugene Barthlow		14. MOTHER'S MAIDEN NAME Julian Snyder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-18-0658	
17. INFORMANT George D. Barthlow, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull - Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian, who was walking in middle of road, hit by car	
20c. TIME OF INJURY Month, Day, Year Dec. 6 19 56 Hour 8:15 AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) Rural- Leitersburg, Wash, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		DATE SIGNED 12-7-56	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 12-9-56	22c. NAME OF CEMETERY OR CREMATORY Southern Methodist	22d. LOCATION (City, town, or county) (State) Martinsburg, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR Dec. 10, 1956	
ADDRESS		24b. REGISTRAR'S SIGNATURE John H. Wood	

RECEIVED

DEC 13 1956

BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page-5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12938

Reg. Dist. No. 302

Item 7 FilmG209 1-4-57 et

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Wash	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN lb 8 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falling Waters,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital		d. STREET ADDRESS 3 Rural - R#1 - Angus Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Edward Harris Bell		4. DATE OF DEATH Month Day Year Dec. 16 19 56	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22 1904
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (State or foreign country) Berryville, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Henry Bell	
14. MOTHER'S MAIDEN NAME Mary Louise Johnson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No -	
16. SOCIAL SECURITY NO. 236-03-8934		17. INFORMANT Address Mrs. Mazie M. Bell- Marlowe, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple fractured ribs DUE TO (b) Haemo-pneumothorax, hemorrhage & shock DUE TO (c) Bilat. pneumonitis, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) alcoholism		INTERVAL BETWEEN ONSET AND DEATH 8 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> Passenger in truck that overturned when driver lost control		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 3:55 Dec. 8 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. # 11		20f. (City or town) (County) (State) Martinsburg Berkeley W. Va.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Dec. 16 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 18, 1956	
22c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery		22d. LOCATION (City, town, or county) (State) Marlowe, West Vir.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert X. Leaf		ADDRESS Williamsport, Md.	
24a. REC'D BY REGISTRAR Dec. 20, 1956		24b. REGISTRAR'S SIGNATURE Black H. Powers	

BUREAU V. S.

DEC 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12939

12952

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 914 Corbett St		d. STREET ADDRESS 17 Cononal Drive	
3. NAME OF DECEASED (Type or print) Sarah Jane Benediot		4. DATE OF DEATH Month 12 Day 22 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1880
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fur Repairer	
11. BIRTHPLACE (State or foreign country) Franklin County Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Daniel Sollenberger		14. MOTHER'S MAIDEN NAME Amanda Keller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. 220-05-6220	
17. INFORMANT J. Ralph Benediot		Address Hag. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension cardiac vascular disease 443K DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diarrhea DUE TO (c) Anemia due to 161		INTERVAL BETWEEN ONSET AND DEATH years years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 Nov , 19 56 , to 22 Dec , 19 56 , that I last saw the deceased alive on 22 Dec , 19 56 , and that death occurred at 10:42 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 W. Maryland St. Hagerstown Md. DATE SIGNED 12/24/56			
ACTUAL SIGNATURE [Signature] M.D.		PHYSICIAN'S NAME (Type) Edmund S. Hagerstown Md.	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 12-24-56	
22c. NAME OF CEMETERY OR CREMATORY Dunkard Cemetery		22d. LOCATION (City, town, or county) (State) Beaver Creek Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR Dec 26 1956		24b. REGISTRAR'S SIGNATURE [Signature]	

BUREAU V. S.

DEC 23 1956

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12953

CERTIFICATE OF DEATH

12940

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 15 Glenside Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle E Last BOSTETTER		4. DATE OF DEATH Month Dec. Day 19 Year 1956					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1897		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 03 Days 03 Hours 03 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Franklin Co. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harry E. Rummel				14. MOTHER'S MAIDEN NAME Elizabeth Eavey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Wilbur S. Bostetter 15 Glenside Ave. Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) 4 yrs.						INTERVAL BETWEEN ONSET AND DEATH 7 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 19, 1956 to Dec. 19, 1956 , that I last saw the deceased alive on Dec. 19, 1956 , and that death occurred at 11:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 214 N. Potomac St. Hagerstown, Md. DATE SIGNED 12/20/56							
ACTUAL SIGNATURE Eloyd A. Hoff		M.D. 214 N. Potomac St. Hagerstown, Md.					
PHYSICIAN'S NAME (Type) Eloyd A. Hoff		Hagerstown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 21, 1956		22c. NAME OF CEMETERY OR CREMATORY Broadfording Cemetery		22d. LOCATION (City, town, or county) (State) Broadfording, Wash. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.				ADDRESS Wash. Co. Hagerstown, Md.		24a. REC'D BY REGISTRAR Dec. 20, 1956	
				24b. REGISTRAR'S SIGNATURE Phyllis H. Powers			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES J. JONES		M		45		JAN 15 1905		ST. LOUIS		MISSOURI		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		SPECIAL OCCUPATION		MILITARY SERVICE	
WHITE		WHITE		CATHOLIC		MARRIED		HIGH SCHOOL		LABORER		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA	
JAN 15 1950		ST. LOUIS		HEART DISEASE		NATURAL		10 DAYS		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE	
J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA	
JAN 15 1950		ST. LOUIS		HEART DISEASE		NATURAL		10 DAYS		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE	
J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	

BUREAU V. 31

REC 26 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12954

CERTIFICATE OF DEATH

Reg. Dist. No.

12941

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 3 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON CO. HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES V. BOWERS				4. DATE OF DEATH Month Day Year 12 2 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/18/1899	9. AGE (In years last birthday) yrs. 57	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY LUMBER		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY B. BOWERS				14. MOTHER'S MAIDEN NAME ELLA LEE BUTTS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 168 -10-7879		17. INFORMANT Address MRS. CYNTHA BOWERS WILLIAMSPORT RT2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Larynx with metastasis</u> 161X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastasis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Oct 1, 1954</u> , to <u>Dec 2, 1956</u> , that I last saw the deceased alive on <u>Dec 1, 1956</u> , and that death occurred at <u>8:55</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>217 W. Washington St. Hagerstown, Md.</u> DATE SIGNED <u>12/3/56</u> ACTUAL SIGNATURE <u>Edward W. Ditto</u> M.D. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto 111, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 5, 1956		22c. NAME OF CEMETERY OR CREMATORY ALPINE CEMETERY		22d. LOCATION (City, town, or county) (State) BROSIOUS W. VA.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Krauss Hagerstown Md</u>				24a. REC'D BY REGISTRAR <u>Dec 5, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 1

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]		5. TIME OF DEATH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. CAUSE OF DEATH [REDACTED]		8. MANNER OF DEATH [REDACTED]		9. PLACE OF BIRTH [REDACTED]	
10. OCCUPATION [REDACTED]		11. EDUCATION [REDACTED]		12. RELIGION [REDACTED]	
13. MARITAL STATUS [REDACTED]		14. PREVIOUS MARRIAGES [REDACTED]		15. PREVIOUS DEATHS [REDACTED]	
16. SIGNATURE OF DECEASED [REDACTED]		17. SIGNATURE OF WITNESS [REDACTED]		18. SIGNATURE OF PHYSICIAN [REDACTED]	
19. SIGNATURE OF CORONER [REDACTED]		20. SIGNATURE OF JURY [REDACTED]		21. SIGNATURE OF JUDGE [REDACTED]	
22. SIGNATURE OF CLERK [REDACTED]		23. SIGNATURE OF REGISTRAR [REDACTED]		24. SIGNATURE OF ARCHIVIST [REDACTED]	

BUREAU V. S.

DEC 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13008

CERTIFICATE OF DEATH

Reg. Dist. No. 12942, 301

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>1 year</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				d. STREET ADDRESS <u>2005 Wolford Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mary E. Brandt</u>				4. DATE OF DEATH <u>December 28</u> 19 <u>56</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15, 1879</u>	
9. AGE (In years, last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John T. McCune</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Atherton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Harry Harman Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Bladder</u> <u>181X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Jan 10</u> , 19 <u>54</u> , to <u>28 Dec</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>26 Dec</u> , 19 <u>56</u> , and that death occurred at <u>12:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. F. Lusby</u>				ADDRESS (Street, city or town, state) <u>230 N. P. Homan</u>			
PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>				DATE SIGNED <u>29 Dec 56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 31, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alfred L. Leaf</u>				ADDRESS <u>Williamsport, Md.</u>		24a. REC'D BY REGISTRAR <u>Dec 29-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>E. Lee McCloy</u>			

CERTIFICATE OF DEATH

Name of Deceased		John Mc Cune	
Age		35	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		None	
Cause of Death		Typhoid Fever	
Date of Death		July 12, 1919	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

BUREAU V. S.

JAN 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12943

12955 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown	
c. LENGTH OF STAY IN 1b 13 days		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Freerick Road	
3. NAME OF DECEASED (Type or print) First FRANK Middle EARL Last BROWN		4. DATE OF DEATH Month December Day 18 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1897
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 7 Days 18 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY Constuction Com.	
11. BIRTHPLACE (State or foreign country) Clevelandville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Brown		14. MOTHER'S MAIDEN NAME Eliza Haupt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 219-05-2019	
17. INFORMANT Charles F. Brown		Address Funkstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio vas. Collapse 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cornary Thrombosis - Infarct DUE TO (c) ARTERIOSCLEROSIS - GEN		INTERVAL BETWEEN ONSET AND DEATH 4 Hrs. Days Yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Fibrosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 9 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 AM , 19 56 , to Dec 18 , 19 56 , that I last saw the deceased alive on Dec 18 , 19 56 , and that death occurred at 1 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis G. Graff M.D.		ADDRESS (Street, city or town, state) 119 E. Antietam DATE SIGNED 12/19/56	
PHYSICIAN'S NAME (Type) Louis G. GRAFF		M.D. Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/20/1956	
22c. NAME OF CEMETERY OR CREMATORY Zittlestown Cemetery		22d. LOCATION (City, town, or county) (State) Zittlestown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Renner		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Dec. 21, 1956		24b. REGISTRAR'S SIGNATURE Thomas H. Powers	

CERTIFICATE OF DEATH

1956

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Race</p>	
<p>4. Date of birth</p>		<p>5. Date of death</p>		<p>6. Place of death</p>	
<p>7. Cause of death</p>		<p>8. Manner of death</p>		<p>9. Signature of physician</p>	
<p>10. Signature of registrar</p>		<p>11. Signature of informant</p>		<p>12. Date of registration</p>	

BUREAU V. 3

DEC 26 1956

RECEIVED

12956

CERTIFICATE OF DEATH

Reg. Dist. No. 12944302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Rest Home		d. STREET ADDRESS 141 Greenmount Ave.	
3. NAME OF DECEASED (Type or print) First Vernon Middle Leon Last Buck		4. DATE OF DEATH Month December Day 30 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 11, 1903 53 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		9b. KIND OF BUSINESS OR INDUSTRY Automobile	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Automobile	
11. BIRTHPLACE (State or foreign country) Rohrersville Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob M. Buck		14. MOTHER'S MAIDEN NAME Lillie S. Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. 214-09-4121	
17. INFORMANT Mrs. Helen Buck		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Lympho Sarcoma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardio-vascular Disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1, 1954 , to Dec. 30, 1956 , that I last saw the deceased alive on Dec. 28, 1956 , and that death occurred at 8:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edward W. Dittus, M.D. 217 W. Washington St. 1/1/57			
ACTUAL SIGNATURE Edward W. Dittus, M.D.			
PHYSICIAN'S NAME (Type) Edward W. Dittus, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-2-57	22c. NAME OF CEMETERY OR CREMATORY Rohrersville Cemetery	22d. LOCATION (City, town, or county) (State) Rohrersville Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR Jan. 4, 1957		24b. REGISTRAR'S SIGNATURE Chas. H. Toward	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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• **McCollum** (1904)

1990

DATE: 3/11/13

154 92 15

BUREAU V. 3

7 JAN 1957

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Wilson

12945

12957

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				d. STREET ADDRESS 1 Maple Ave		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SIDNEY Middle KAY Last BURKER				4. DATE OF DEATH Month Dec Day 29 Year 1956 19 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 25 1956	
9. AGE (In years last birthday) yrs. 4		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Hagerstown Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Arnold J. Burker			
14. MOTHER'S MAIDEN NAME Mildred J. Bowling				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----			
16. SOCIAL SECURITY NO. None				17. INFORMANT Arnold J. Burker Funkstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 12/25/56				20g. (County) 12/29/56		20h. (State) 12/31/56	
21. I certify that I attended the deceased from 12/25/56 to 12/29/56 , that I last saw the deceased alive on 12/28/56 , and that death occurred at 12 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) 135 No. Potomac			
PHYSICIAN'S NAME (Type) [Signature]				DATE SIGNED 12/31/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/56		22c. NAME OF CEMETERY OR CREMATORY Mennonite Cemetery		22d. LOCATION (City, town, or county) (State) Pinesburg Wash. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.			
24a. REC'D BY REGISTRAR Jan. 2. 1957				24b. REGISTRAR'S SIGNATURE [Signature]			

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CERTIFICATE OF DEATH

BUREAU V. S.

AN 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13009

CERTIFICATE OF DEATH

12946

Reg. Dist. No. 300

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Antietam RFD</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sharpsburg RFD #1</u>				d. STREET ADDRESS <u>Sharpsburg RFD #1</u>			
3. NAME OF DECEASED (Type or print) <u>Lloyd Russel Campbell</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 9, 1901</u>		9. AGE (In years lost birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria Employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild Aircraft</u>		11. BIRTHPLACE (State or foreign country) <u>Antietam Furnace</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Robert Lee Campbell</u>				14. MOTHER'S MAIDEN NAME <u>Annie Mae Boyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-10-3758</u>		17. INFORMANT <u>Sarah Campbell Antietam Sharpsburg RFD #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.0</u> (c) <u>1 hour</u> <u>1 Yr (?)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>1</u> p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Dec. 1</u> , 19 <u>55</u> , to <u>12/22/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 12</u> , 19 <u>56</u> , and that death occurred at <u>8:10A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter H. Shealy</u>				ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u>		DATE SIGNED <u>12/24/56</u>	
PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 24 '56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mountainview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpsburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>				ADDRESS <u>Williamsport, Md.</u>		24a. REC'D BY REGISTRAR <u>Dec 24 '56</u>	
				24b. REGISTRAR'S SIGNATURE <u>E. G. Boyer</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF BURIAL SOCIETY	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF CHURCH		21. SIGNATURE OF CEMETERY	
22. SIGNATURE OF MINISTER		23. SIGNATURE OF CLERGY		24. SIGNATURE OF RABBI	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V.

DEC 27 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr Wells 12947

Reg. Dist. No. 302

12958

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 Hr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hagerstown Police Headquarters			d. STREET ADDRESS 411 Clarendon Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JOHN ROGER CARBAUGH			4. DATE OF DEATH Month Day Year Dec 23 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 14 1921		9. AGE (In years last birthday) 35 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Hagerstown Md.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Andrew Carbaugh			14. MOTHER'S MAIDEN NAME Nellie Knable		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) W.W.#2			16. SOCIAL SECURITY NO. Unable to locate		
17. INFORMANT Mrs Evelyn Spickler Hagerstown Md.			Address 411 Clarendon Ave		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation by hanging DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 974x (c) Chronic alcoholism					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic alcoholism					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanged self in jail cell with shirt			
20c. TIME OF INJURY Month, Day, Year Dec. 22, 1956 Hour 11:50 m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Jail Cell	
20f. (City or town) Hagerstown		20g. (County) Wash		20h. (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE S. Robert Wells			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) S. Robert Wells, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 26/56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
22d. LOCATION (City, town, or county) Hagerstown, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman			ADDRESS Hagerstown, Md.		
24a. REC'D BY REGISTRAR Dec. 27, 1956			24b. REGISTRAR'S SIGNATURE W. H. Bowers		

RECEIVED

DEC 27 1956

BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13010

CERTIFICATE OF DEATH

Reg. Dist. No. 305

12948

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro				c. LENGTH OF STAY IN 1b SINCE 4-6-55		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Airy-Rural RD#1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reeder's Nursing Home				d. STREET ADDRESS McKaig		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NICIE OCTAVIA CASTLE				4. DATE OF DEATH Month Day Year December 11, 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 Oct 1873	
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John H. Etzler				14. MOTHER'S MAIDEN NAME Jane R. Cane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address James H. Castle, RD#1, Mount Airy, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carotid artery - 174x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1, 1956 , to Dec 11, 1956 , that I lost saw the deceased alive on December 10, 1956 , and that death occurred at 10:15 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE G. W. Whelan				ADDRESS (Street, city or town, state) Boonsboro		DATE SIGNED 12/11/56	
PHYSICIAN'S NAME (Type) G. W. Whelan				Boonsboro, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 13 Dec 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS Frederick, Maryland		24c. REC'D BY REGISTRAR DATE Dec 13, 1956	
				24b. REGISTRAR'S SIGNATURE John H. Baird			

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. CONLEY		AGE 38		SEX Male		RACE White		DATE OF DEATH Dec 17 1956		PLACE OF DEATH Home	
RESIDENCE 1000 N. ...		BIRTH ...		MARRIAGE ...		OCCUPATION ...		CAUSE OF DEATH ...		MANNER OF DEATH ...	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF ...	

BUREAU V. 2

DEC 17 1956

RECEIVED

13011

CERTIFICATE OF DEATH

12949

Reg. Dist. No. 304

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown Md				c. LENGTH OF STAY IN 1b 1 Yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gate Way Nursing Home				d. STREET ADDRESS Hancock Maryland.			
3. NAME OF DECEASED (Type or print) First Bessie Middle Ellen Last Daniels				4. DATE OF DEATH Month 12 Day 7 Year 19 56			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22. 1877		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 10 Days 15 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Labor		11. BIRTHPLACE (State or foreign country) Fulton County Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Daniels				14. MOTHER'S MAIDEN NAME Elizabeth Sipes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Cora Shaw Hancock Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Feb 15, 1956 , to Dec 7, 1956 , that I last saw the deceased alive on Dec 7, 1956 , and that death occurred at 6:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Clear Spring Md. DATE SIGNED 12/10/56							
ACTUAL SIGNATURE David R. Brewer M.D.				PHYSICIAN'S NAME (Type) DAVID R. BREWER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12.10.56		22c. NAME OF CEMETERY OR Mercersburg Penna		22d. LOCATION (City, town, or county) (State) Mercersburg Penna	
23. FUNERAL DIRECTOR'S SIGNATURE Hancock & Sons Hancock Md				24a. REC'D BY REGISTRAR DATE 12/12		24b. REGISTRAR'S SIGNATURE F. A. Miller	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. B.

DEC 14 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13950**

13012

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg c. LENGTH OF STAY IN 1b 301 Main St. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 301 Main St.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg d. STREET ADDRESS 301 Main Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Betty Jane DeLauney				4. DATE OF DEATH Month December Day 2 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 24 1927	
9. AGE (In years last birthday) 29 yrs.		10. IF UNDER 1 YEAR Months 3 Days 29		11. IF UNDER 24 HRS. Hours 29 Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper				10b. KIND OF BUSINESS OR INDUSTRY Acme Store		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME John Garland Moore				14. MOTHER'S MAIDEN NAME Minnie Myrtle Kidwiller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-20-8512		17. INFORMANT William T. DeLauney Address Sharpsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun Shot thru heart region (Hemorrhage and shock) DUE TO (b) 976x Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with 22 hornet rifle			
20c. TIME OF INJURY Month, Day, Year 12-3 1956 Hour 12:00 PM		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home		20f. (City or town) Sharpsburg (County) Wash (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec. 6 1956		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE Edith T. Leaf				ADDRESS Williamsport Md.		24a. REC'D BY REGISTRAR Wms 7954	
				24b. REGISTRAR'S SIGNATURE E. A. Boyer		DATE 12-4-56	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 10 1956
BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12951

13013

CERTIFICATE OF DEATH

Reg. Dist. No.

301

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport c. LENGTH OF STAY IN 1b 30 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 33 E. Church St.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport d. STREET ADDRESS 33 E. Church St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Victor Charles Ditto				4. DATE OF DEATH Month December Day 4 Year 19 56															
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 6, 1875		9. AGE (In years, lost birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith				10b. KIND OF BUSINESS OR INDUSTRY Tool, Pattern-maker				11. BIRTHPLACE (State or foreign country) West Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Greenbury Clinton DeWitt				14. MOTHER'S MAIDEN NAME Mary Elizabeth Miller				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs. Victor C. Ditto Address 33 E. Church St. Williamsport, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 yrs												INTERVAL BETWEEN ONSET AND DEATH 4 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour a. 11 p. m. Month 19 Day 19 Year 19 56				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Williamsport		(County) Washington		(State) Md.							
21. I certify that I attended the deceased from 7-1-56 , 19 56 , to 12-4 , 19 56 , that I last saw the deceased alive on 12-1-56 , 19 56 , and that death occurred at Williamsport, Md. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Williamsport, Md. DATE SIGNED 12/4/56 ACTUAL SIGNATURE V. C. Ditto M.D. Harold A. Hays PHYSICIAN'S NAME (Type) V. C. Ditto Harold A. Hays																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec. 7, '56		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery				22d. LOCATION (City, town, or county) (State) Western Pike Maryland									
23. FUNERAL DIRECTOR'S SIGNATURE Edith V. Leaf				ADDRESS Williamsport, Md.				24a. REC'D BY REGISTRAR Dec 6-1956		24b. REGISTRAR'S SIGNATURE E. Lee M. Elroy									

BUREAU V. S.

DEC 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12952

Reg. Dist. No.

302

12959

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brownsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>American Legion Home Northern Ave.</u>				d. STREET ADDRESS <u>Knoxville, Md. Rt. #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>David Christopher Downs</u>				4. DATE OF DEATH Month Day Year <u>Dec. 14 1956</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 20, 1886</u>		
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool tender</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild Air.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles H. Downs</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Gossard</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <input checked="" type="checkbox"/> <u>World War I</u>				16. SOCIAL SECURITY NO. <u>213-16-1470A</u>		17. INFORMANT <u>Mrs. Alta Mills Knoxville, Md. RFD #1</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic myocardial heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Acute Coronary Occlusion</u> (c) <u>420.1</u> DUE TO (c) <u>260x</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes M</u>							INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Hour o. m. p. m. <u>None 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>- - -</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		12-14-56		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 16, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert A. Leaf</u>				ADDRESS <u>Williamsprt, Md.</u>		24a. REC'D BY REGISTRAR <u>Dec. 18, 1956</u>		
				24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Last Name		First Name		Middle Name	
Date of Birth		Place of Birth		Country of Birth	
Date of Death		Place of Death		Cause of Death	
Occupation		Education		Religion	
Marital Status		Previous Illnesses		Alcohol Consumption	
Tobacco Use		Drugs		Mental Health	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	

BUREAU V. S.

DEC 20 1956

RECEIVED

11/21/56

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12953-305

13014

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO RURAL				c. LENGTH OF STAY IN 1b 4 DAYS					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BOONSBORO MD. R. 2				d. STREET ADDRESS MAIN STREET					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Keturah P. Enyart				4. DATE OF DEATH DECEMBER - 24 - 19 56					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE - 1 - 1883			
9. AGE (In years last birthday) 73 yrs.		10. AGE (In years last birthday) 73 yrs.		11. BIRTHPLACE (State or foreign country) INDIANA		12. CITIZEN OF WHAT COUNTRY? USA USA			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME NO RECORD					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) np				16. SOCIAL SECURITY NO. NONE					
17. INFORMANT MRS. BARBARA ALLEN RINCONATI				Address 5013 Knightly DR NW 27 OHIO					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465X Acute pulmonary artery thrombosis DUE TO Pancreatic abscess Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Infarct (Thrombophlebitis femoral artery) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 47 days 1 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none			
20f. (City or town) -				20g. (County) -		20h. (State) -			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED Dec. 24 '56					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Dec 27, 1956		22c. NAME OF CEMETERY OR CREMATORY NATIONAL MEMORIAL PARK CEMETERY FALLS CHURCH VIRGINIA		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS EAST FUNERAL HOME BOONSBORO MD				24a. REC'D BY REGISTRAR DATE Dec 27 1956		24b. REGISTRAR'S SIGNATURE John A. Paul			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
FAMILY HISTORY		PREVIOUS ILLNESS		TOXIC		INFECTIOUS		TUMOR		OTHER	
FINDINGS AT AUTOPSY		GROSS		MICROSCOPIC		TOXIC		INFECTIOUS		TUMOR	
LABORATORY TESTS		HISTOLOGY		BACTERIOLOGY		CHEMISTRY		PHYSIOLOGY		OTHER	
FINDINGS AT AUTOPSY		GROSS		MICROSCOPIC		TOXIC		INFECTIOUS		TUMOR	
LABORATORY TESTS		HISTOLOGY		BACTERIOLOGY		CHEMISTRY		PHYSIOLOGY		OTHER	

BUREAU V. 3

JAN 7 1957

RECEIVED

13015

CERTIFICATE OF DEATH

12954

Reg. Dist. No.

303

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CUMBERLAND STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LILLIAN Middle MAE Last FRANTZ		4. DATE OF DEATH Month 12 Day 12 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 25, 1872
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB REED		14. MOTHER'S MAIDEN NAME FANNIE KREPS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. REED FRENTZ		Address CLEAR SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Hypertensive Arteriosclerotic Heart Disease IMMEDIATE CAUSE (a) 420.0 DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 6, 1954 to Dec. 12, 1956 , that I last saw the deceased alive on Dec. 12, 1956 , and that death occurred at 12:10 pm from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Archie Robert Cohen, M.D.		PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D. Clear Spring, Maryland 12/14/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/17/56	
22c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEMETERY		22d. LOCATION (City, town, or county) (State) CLEAR SPRING, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark Clear Spring, Md.		24a. REC'D BY REGISTRAR DATE Dec 17-56	
24b. REGISTRAR'S SIGNATURE Joseph W. Murray			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 FilmG209 1-4-57 et
Dr Robt Campbell
CERTIFICATE OF DEATH
Reg. Dist. No. 302

12960

12955

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 Hr d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 717 Orchard Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NANCY FRIEND FRANTZ		4. DATE OF DEATH Month Day Year December 23 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 22 1873
9. AGE (In years last birthday) 83/84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) near Hagerstown Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jacob Friend	
14. MOTHER'S MAIDEN NAME Alice Hill		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Nancy Friend Sica Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis of the vessels (c) generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 hr 2 wk 8-10 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hagerstown		(County) (State)	
21. I certify that I attended the deceased from Jan 33 , 19 56 , to Dec 23 , 19 56 , that I last saw the deceased alive on Dec 23 , 19 56 , and that death occurred at 12 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 454 W Washington St Hagerstown Md DATE SIGNED md			
ACTUAL SIGNATURE Robert V. H. Campbell		M.D. md	
PHYSICIAN'S NAME (Type) Robert V. H. Campbell M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/26/56	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR Dec 27 1956		24b. REGISTRAR'S SIGNATURE Robert H. Bowers	

CERTIFICATE OF DEATH

1956

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13016

CERTIFICATE OF DEATH

12956

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halfway</u>				c. LENGTH OF STAY IN 1b <u>7 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halfway</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1827 Heisterboro Road</u>				d. STREET ADDRESS <u>1827 Heisterboro Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Martha Lewis Garrett</u>				4. DATE OF DEATH Month Day Year <u>Dec. 29 19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 16, 1879</u>	
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Near Williamsport, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Boppe</u>				14. MOTHER'S MAIDEN NAME <u>Mary Cunningham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Carroll Stauffer</u> <u>1827 Heisterboro Rd. Halfway, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town). (County) (State)							
21. I certify that I attended the deceased from <u>12/29/56</u> , 19 <u>56</u> , to <u>12/29/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/29/56</u> , 19 <u>56</u> , and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Williamsport, Md.</u> DATE SIGNED <u>12/30/56</u>							
ACTUAL SIGNATURE <u>Ralph E. Young</u> M.D.				PHYSICIAN'S NAME (Type) <u>Ralph E. Young</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mennonite Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pinesburg, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Zopf</u>				ADDRESS <u>Williamsport, Md.</u>		24a. REC'D BY REGISTRAR <u>Jan. 3, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles C. Cowers</u>							

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Jan 1, 1957		Home		Heart Disease	
Time of Death		Manner of Death		Signature of Physician	
10:00 AM		Natural		[Signature]	
Name of Informant		Relationship		Signature of Informant	
Jane Doe		Wife		[Signature]	
Address		City		State	
123 Main St		Baltimore		MD	
Telephone		Hospital		Burial Place	
[Number]		[Name]		[Name]	

RECEIVED
JAN 7 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12957

Reg. Dist. No. 302

12961

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>60 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>118 East Ave.</u>				d. STREET ADDRESS <u>118 East Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA</u> <u>SUSAN</u> <u>GARVER</u>				4. DATE OF DEATH Month Day Year <u>December</u> <u>9</u> <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>April 5, 1866</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u>		11. IF UNDER 24 HRS. Hours <u>4</u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Smithsburg, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Martin Harbaugh</u>				14. MOTHER'S MAIDEN NAME <u>Susan Barkdoll</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT Address <u>Mrs. Melchora Barnes</u> <u>Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebral hemorrhage</u> DUE TO (b) <u>331x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>--</u> <u>--</u> <u>--</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/12/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Ronger</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Dec. 15, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>East Bowers</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Death		6. Cause of Death		7. Manner of Death		8. Signature of Medical Examiner	
9. Signature of Coroner		10. Signature of Physician		11. Signature of Nurse		12. Signature of Undertaker	
13. Signature of Witness		14. Signature of Juror		15. Signature of Juror		16. Signature of Juror	
17. Signature of Juror		18. Signature of Juror		19. Signature of Juror		20. Signature of Juror	
21. Signature of Juror		22. Signature of Juror		23. Signature of Juror		24. Signature of Juror	
25. Signature of Juror		26. Signature of Juror		27. Signature of Juror		28. Signature of Juror	
29. Signature of Juror		30. Signature of Juror		31. Signature of Juror		32. Signature of Juror	
33. Signature of Juror		34. Signature of Juror		35. Signature of Juror		36. Signature of Juror	
37. Signature of Juror		38. Signature of Juror		39. Signature of Juror		40. Signature of Juror	
41. Signature of Juror		42. Signature of Juror		43. Signature of Juror		44. Signature of Juror	
45. Signature of Juror		46. Signature of Juror		47. Signature of Juror		48. Signature of Juror	
49. Signature of Juror		50. Signature of Juror		51. Signature of Juror		52. Signature of Juror	
53. Signature of Juror		54. Signature of Juror		55. Signature of Juror		56. Signature of Juror	
57. Signature of Juror		58. Signature of Juror		59. Signature of Juror		60. Signature of Juror	
61. Signature of Juror		62. Signature of Juror		63. Signature of Juror		64. Signature of Juror	
65. Signature of Juror		66. Signature of Juror		67. Signature of Juror		68. Signature of Juror	
69. Signature of Juror		70. Signature of Juror		71. Signature of Juror		72. Signature of Juror	
73. Signature of Juror		74. Signature of Juror		75. Signature of Juror		76. Signature of Juror	
77. Signature of Juror		78. Signature of Juror		79. Signature of Juror		80. Signature of Juror	
81. Signature of Juror		82. Signature of Juror		83. Signature of Juror		84. Signature of Juror	
85. Signature of Juror		86. Signature of Juror		87. Signature of Juror		88. Signature of Juror	
89. Signature of Juror		90. Signature of Juror		91. Signature of Juror		92. Signature of Juror	
93. Signature of Juror		94. Signature of Juror		95. Signature of Juror		96. Signature of Juror	
97. Signature of Juror		98. Signature of Juror		99. Signature of Juror		100. Signature of Juror	

RECEIVED
DEC 17 1956
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12962

CERTIFICATE OF DEATH

Reg. Dist. No.

12950
302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 2 yrs.2 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 03		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Home				d. STREET ADDRESS 305 Reynolds Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle E Last GERBERICH				4. DATE OF DEATH Month Dec. Day 21 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec.25,1864	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months 21 Days 21 Hours 1956		IF UNDER 24 HRS. Months 21 Days 21 Hours 1956			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.Hershey Chocolate Co.				10b. KIND OF BUSINESS OR INDUSTRY Candy		11. BIRTHPLACE (State or foreign country) Linglestown,Dolphin Co.Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Joseph Gerberich				14. MOTHER'S MAIDEN NAME Susanna Gingerich			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 187-03-9487		17. INFORMANT Mr.John H.Gerberich Address 305 Reynolds Ave. Hagerstown,Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Genus Arteriosclerosis DUE TO (c) Senility							INTERVAL BETWEEN ONSET AND DEATH 15 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12-20 , 19 56 , to 12-21 , 19 56 , that I last saw the deceased alive on 12-20-56 , 19 56 , and that death occurred at 12:39 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE E. W. Ditto M.D.				ADDRESS (Street, city or town, state) 215 W. Washington St. Hagerstown, Md. DATE SIGNED 12/21/56			
PHYSICIAN'S NAME (Type) E.W Ditto M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec.24,1956		22c. NAME OF CEMETERY OR CREMATORY Gravel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Palmyra Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.				ADDRESS Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR Dec 23, 1956 24b. REGISTRAR'S SIGNATURE Phas H. Bowers	

Wm. G. Hoot O. Pres.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12953
CERTIFICATE OF DEATH

12959

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>821 Mulberry Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>VIOLA</u> Last <u>GLASS</u>		4. DATE OF DEATH Month <u>December</u> Day <u>24</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 13, 1904</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>11</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired cafeteria manager Board of Education Harrisburg, Penn.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Swartzbaugh</u>		14. MOTHER'S MAIDEN NAME <u>Ida Lily Free</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. H. B. Colgrove</u>		Address <u>New Augusta, Indiana</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Agrenulocytosis</u> <u>297x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Asthma general</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1953</u> to <u>Dec 24, 1956</u> , that I last saw the deceased alive on <u>24 Dec 1956</u> , and that death occurred at <u>1030 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin H. Overholser</u> M.D.		ADDRESS (Street, city or town, state) <u>115 W. Main</u> DATE SIGNED <u>12/26</u>	
PHYSICIAN'S NAME (Type) <u>Edwin H. Overholser</u>		<u>Hagerstown Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/27/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mountain View Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Sharpsburg, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Super-Rouzer Funeral Home</u> <u>R. Franklin Rouse</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>Dec. 29, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Sheila Powers</u>	

CERTIFICATE OF DEATH

THE DEPT. OF HEALTH

NAME OF DECEASED		DATE OF DEATH	
JAMES J. JONES		JAN 1 1957	
AGE		SEX	
61 years		Male	
RACE		EDUCATION	
White		High School	
OCCUPATION		RESIDENCE	
Retired		101 W. 1st St. Baltimore, Md.	

CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
DISEASE OR INJURY		PLACE OF DEATH	
Myocardial Infarction		Home	
DATE OF DEATH		TIME OF DEATH	
JAN 1 1957		10:00 AM	
PLACE OF DEATH		RESIDENCE	
Home		101 W. 1st St. Baltimore, Md.	

SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. J. Jones		J. J. Jones	
DATE		DATE	
JAN 1 1957		JAN 1 1957	

BUREAU V. S.

JAN 2 1957

RECEIVED

FILING		RECORDS	
JAN 2 1957		JAN 2 1957	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12964

CERTIFICATE OF DEATH

12960
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1908 YORK RD.		d. STREET ADDRESS 1908 YORK RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FINDLAY Middle VANLEAR Last GOSSARD		4. DATE OF DEATH Month DECEMBER Day 29 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/15/1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED GARDNER		10b. KIND OF BUSINESS OR INDUSTRY FLOREST	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DAVID GOSSARD	
14. MOTHER'S MAIDEN NAME MAGGIE WATKINS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 214-09-1315		17. INFORMANT MRS FRANCES BOWARD Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiparesis Cause Unknown 420.0 DUE TO Coronary Insufficiency due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Heart Disease DUE TO (c) Emphysema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema			INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 8 , 19 55 , to Dec 29 , 19 56 , that I last saw the deceased alive on Dec 29 , 19 56 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Sidney Noveston M.D.		ADDRESS (Street, city or town, state) Hagerstown Md DATE SIGNED 12-31-57	
PHYSICIAN'S NAME (Type) SIDNEY NOVESTON			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/1/57	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment Address Hagerstown, Md.		24a. REC'D BY REGISTRAR Jan. 2, 1957	24b. REGISTRAR'S SIGNATURE Frances Boward

CERTIFICATE OF DEATH

NAME OF DECEASED DAVID G. GORDON		DATE OF DEATH JAN 2 1957	
PLACE OF DEATH BALTIMORE, MARYLAND		AGE 45	
OCCUPATION ENGINEER		CAUSE OF DEATH CORONARY THROMBOSIS	
MANNER OF DEATH NATURAL		SIGNATURE OF PHYSICIAN J. H. GORDON	
SIGNATURE OF DECEASED DAVID G. GORDON		SIGNATURE OF WITNESSES J. H. GORDON, J. H. GORDON	
LOCAL HEALTH OFFICER J. H. GORDON		COUNTY CLERK J. H. GORDON	

BUREAU V. 8

JAN 2 1957

RECEIVED

13017

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GATEWAY NURSING HOME		d. STREET ADDRESS WESTERN PIKE	
3. NAME OF DECEASED (Type or print) First EMMA Middle GRAY Last		4. DATE OF DEATH Month 12 Day 1 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 16, 1868
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) PENNA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNKNOWN	
14. MOTHER'S MAIDEN NAME UNKNOWN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT WILLIAM E. MOORE HAGERSTOWN, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Arterial Sclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 mo. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 15, 1956 to Dec 1, 1956 that I last saw the deceased alive on Jan 1, 1957 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE David R. Brewer M.D.			
PHYSICIAN'S NAME (Type) David R. Brewer Clear Spring Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF DEC. 3, 1956	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	22d. LOCATION (City, town, or county) (State) HAGERSTOWN, MD.
23. FUNERAL DIRECTOR'S SIGNATURE F. W. Kraiss ADDRESS Hagerstown Md		24a. REC'D BY REGISTRAR Dec 6-56	24b. REGISTRAR'S SIGNATURE Wayne Fochler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12965

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>836 HAMILTON BLVD</u>		d. STREET ADDRESS <u>836 HAMILTON BLVD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SUSAN DUCKETT GROVE</u>		4. DATE OF DEATH Month Day Year <u>DECEMBER - 12, 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DECEMBER - 31 - 1874</u>
9. AGE (In years last birthday) <u>81</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BAKERSVILLE WASH. Co. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DR. RICHARD J. DUCKETT</u>		14. MOTHER'S MAIDEN NAME <u>ANN LOUISE WILSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years</u> <u>4 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 23, 1956</u> , to <u>Dec. 12, 1956</u> , that I last saw the deceased alive on <u>December 12, 1956</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. T. Layman, M.D.</u>		DATE SIGNED <u>12-14-56</u>	
PHYSICIAN'S NAME (Type) <u>William T. Layman</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Dec. 15, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARKS CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>LAPPANS WASH. Co. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME BOONSBORO MD</u>		24a. REC'D BY REGISTRAR <u>Dec. 18, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Powers</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12963

Item 7, Film G209, 1/7/57 fcy CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> 03	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>437 GUILFORD AVE.</u>		d. STREET ADDRESS <u>437 GUILFORD AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>L</u> Last <u>HAGER</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>18</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY - 6 - 1906</u>
9. AGE (In years last birthday) <u>50-11-12</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW MARTINSVILLE W.VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MATHIAS JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>ELEANORA MCCAUSLAND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>MISS SARA L. JOHNSON</u>		Address <u>437 GUILFORD AVE HAGERSTOWN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer R. Bowel</u> <u>170x</u> DUE TO <u>Intestinal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Intestinal</u> (c) <u>Intestinal</u> INTERVAL BETWEEN ONSET AND DEATH <u>04-14-54</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 19</u> , 19 <u>54</u> , to <u>Dec 18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 18</u> , 19 <u>56</u> , and that death occurred at <u>10:15 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sidney Novenster</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>12-14-56</u>	
PHYSICIAN'S NAME (Type) <u>SIDNEY NOVENSTER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC 21 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>		ADDRESS <u>BOONSBURG MD.</u>	
24a. REC'D BY REGISTRAR <u>Dec 24 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Robert Bowers</u>	

DR. NOVENSTEIN

FUNKSTOWN MD.

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12967

CERTIFICATE OF DEATH

12964

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>6 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sharpsburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>Route 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen</u> First <u>Clementine</u> Middle <u>Hammersla</u> Last				4. DATE OF DEATH <u>December</u> Month <u>1</u> Day <u>56</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 13, 1905</u>	
9. AGE (In years lost birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Charles E. Daley</u>				14. MOTHER'S MAIDEN NAME <u>Estella Alexander</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT <u>Russell E. Hammersla</u> Address <u>Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Vascular Disease</u> (c) <u>Tubercle</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> <u>4 yrs</u> <u>5 wks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10-26</u> , 19 <u>56</u> , to <u>12-1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-30</u> , 19 <u>56</u> , and that death occurred at <u>7</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ed W. Ditto, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u> DATE SIGNED <u>12/3/56</u>			
PHYSICIAN'S NAME (Type) <u>Edward W. Ditto, Jr. M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-4-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u> ADDRESS <u>Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>Dec 5, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Phyllis Bowers</u>	

BUREAU V.

DEC 7 1956

RECEIVED

12968

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
c. LENGTH OF STAY IN 1b <u>3 Weeks</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>137 No Locust St.</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GOLDIE MAE HARBAUGH</u>				4. DATE OF DEATH Month Day Year <u>December 7 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 23 1898</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Brunswick Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Mann</u>				14. MOTHER'S MAIDEN NAME <u>Annie F. Mills</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Marshall E. Harbaugh Sr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary infarct</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholecystectomy + Ventral Herniorrhaphy 11-19-56</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>12-6-56</u> <u>12-1-56</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 12</u> , 19 <u>56</u> , to <u>Dec. 7</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Dec 7</u> , 19 <u>56</u> , and that death occurred at <u>9:20 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sidney Novenstein</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>2400 4th St Sd</u> <u>12-8-56</u>			
PHYSICIAN'S NAME (Type) <u>SIDNEY NOVENSTEIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Dec. 10. 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 13 1956

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED: [illegible]	
2. SEX: [illegible]	
3. AGE: [illegible]	
4. DATE OF BIRTH: [illegible]	
5. PLACE OF BIRTH: [illegible]	
6. DATE OF DEATH: [illegible]	
7. PLACE OF DEATH: [illegible]	
8. CAUSE OF DEATH: [illegible]	
9. MANNER OF DEATH: [illegible]	
10. SIGNATURE OF PHYSICIAN: [illegible]	
11. SIGNATURE OF REGISTRAR: [illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13018

CERTIFICATE OF DEATH

Reg. Dist. No.

12966

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO		c. LENGTH OF STAY IN 1b 33 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REEDER NURSING HOME		d. STREET ADDRESS INDIAN SPRINGS	
3. NAME OF DECEASED (Type or print) First MIDDLE Last JOSEPH HAGER HARR		4. DATE OF DEATH Month 12 Day 10 Year 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 2, 1877
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAR INSPECTOR		10b. KIND OF BUSINESS OR INDUSTRY W.M.R.R.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID HARR		14. MOTHER'S MAIDEN NAME LUCY MYERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. MARY SOLLENBERGER		Address BIG POOL RT1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 8, 1956 to Dec 10, 1956, that I last saw the deceased alive on Dec 9, 1956, and that death occurred at 2 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE G. W. LeVan		M.D. Boonsboro	
PHYSICIAN'S NAME (Type) G. W. LeVan		DATE SIGNED 12/11/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/13/56	
22c. NAME OF CEMETERY OR CREMATORY SHANKTOWN CEMETERY		22d. LOCATION (City, town, or county) (State) SHANKTOWN WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark		ADDRESS Clear Spring, Md	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE John H. Ball	
DATE Dec. 13, 1956			

RECEIVED
DEC 21 1956
BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12969

CERTIFICATE OF DEATH

Reg. Dist. No. 129672

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 20 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 735 Washington Ave.				d. STREET ADDRESS 735 Washington Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Melton Last Harsh				4. DATE OF DEATH Month December Day 12 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1874		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Harsh				14. MOTHER'S MAIDEN NAME Amelia Zellers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-3940		17. INFORMANT George Harsh Hagerstown, Md. Address 308 Vale St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 yrs DUE TO (c) 10 yrs							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 9 p. m. Month, Day, Year 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-1-1956 , to 12-12-1956 , that I last saw the deceased alive on 12-9-56 , 12, and that death occurred at 8 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. E. W. Dittus		M.D. Hagerstown Md		ADDRESS (Street, city or town, state)		DATE SIGNED 12/12/56	
PHYSICIAN'S NAME (Type) Dr. E. W. Dittus		Hagerstown Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 15, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) Western Pike Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert A. Leaf		ADDRESS Williamsport, Md.		24a. REC'D BY REGISTRAR Dec 18, 1956		24b. REGISTRAR'S SIGNATURE Phyllis Bowers	

CERTIFICATE OF DEATH

NAME OF DECEASED JACOB BARNES		SEX Male	
DATE OF BIRTH 1880		PLACE OF BIRTH Maryland	
DATE OF DEATH 1956		PLACE OF DEATH Baltimore, Md.	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED (Blank)		SIGNATURE OF WITNESS (Blank)	
SIGNATURE OF PHYSICIAN (Blank)		SIGNATURE OF CORONER (Blank)	
SIGNATURE OF REGISTRAR (Blank)		SIGNATURE OF CLERK (Blank)	

BUREAU V. S.

DEC 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12968									
S. Robert Wells, M.D. Dist. 56 D.M.E. Wash. Co.										Reg. Dist. No. 302									
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE					b. COUNTY									
Washington					Maryland					Washington									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
Hagerstown Md.					7 Months					Hagerstown Maryland									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
412 N. Jonathan Street					412 N. Jonathan Street														
3. NAME OF DECEASED (Type or print)					First	Middle	H	Lost	4. DATE OF DEATH	Month	Day	Year							
Mary					Jane					Dec	2	1956							
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
Female		Colored				4-12-1873		83 yrs.		Months		Days	Hours	Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
Housewife					Own home					Charlestown, W. Va.					USA				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME														
Willis Tryman					Jane Tucker														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT		Address										
					none		Mrs Rachel Johnson		Charlestown W. Va										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral concussion 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) fall DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) hypertensive and arteriosclerotic heart disease--indeterminate										INTERVAL BETWEEN ONSET AND DEATH 34 hrs.									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fell down flight of stairs backwards (13 steps)									
20c. TIME OF INJURY Hour a. m. p. m.				Month.		Day.		Year		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Hagerstown		(County) Washington		(State) Md.	
10:30				Nov.		29		1956											
21. I certify that I attended the deceased from Nov. 29, 1956, to Dec. 2, 1956, that I last saw the deceased alive on Dec. 1, 1956, and that death occurred at 8:30 A.M., from the causes and on the date stated above.										ADDRESS (Street, city or town, state) 100 Professional Arts Bldg.				DATE SIGNED 12-3-56					
ACTUAL SIGNATURE W. J. Layman, M.D.																			
PHYSICIAN'S NAME (Type) William T. Layman, M.D.										Hagerstown, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county)				(State)					
Burial				11-5-1956		Rose Hill Cemetery				Hagerstown				Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr.										ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Dec 5, 1956		24b. REGISTRAR'S SIGNATURE Phyllis Cowers					

CERTIFICATE OF DEATH

PLACE TO BE FILLED BY THE REGISTRAR		PLACE TO BE FILLED BY THE PHYSICIAN	
NAME OF DECEASED		DATE OF DEATH	
AGE		SEX	
RACE		OCCUPATION	
EDUCATION		MANNER OF DEATH	
CAUSE OF DEATH		PLACE OF DEATH	
DATE OF BURIAL		PLACE OF BURIAL	
SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN	
DATE		DATE	
PLACE		PLACE	
COUNTY		COUNTY	
CITY		CITY	
STATE		STATE	
FEDERAL BUREAU OF INVESTIGATION		FEDERAL BUREAU OF INVESTIGATION	
U.S. DEPARTMENT OF JUSTICE		U.S. DEPARTMENT OF JUSTICE	
WASHINGTON, D.C.		WASHINGTON, D.C.	

BUREAU V. S.

DEC 7 1956

RECEIVED

Handwritten signature and date: 12/11/56

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12971

CERTIFICATE OF DEATH

12969

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GERTRUDE</u> First <u>FAY</u> Middle <u>HAWTHORNE</u> Last				4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>19 56</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 29, 1875</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Boonsboro, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Lawson Wilkinson</u>				14. MOTHER'S MAIDEN NAME <u>Julia ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>William H. Hawthorne</u> Address <u>Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive myocardial heart disease with</u> <u>443X</u> DUE TO <u>myocardial failure grade iv</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>none</u> 19 <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>October</u> , 19 <u>54</u> to <u>Dec. 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 6</u> , 19 <u>56</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. <u>115 N. Potomac Street</u>		DATE SIGNED <u>12-7-56</u>	
PHYSICIAN'S NAME (Type) <u>S. Robert Wells, M.D.</u>				<u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Rogers</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Dec 10, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas H. Powers</u>			

BUREAU V. S.

DEC 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12970

12972

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARTIN MANOR REST HOME		d. STREET ADDRESS RT#3 HAGERSTOWN	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LEWIS First HITE Middle HITE Last		4. DATE OF DEATH Month DECEMBER Day 31 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/9/1878
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TRAINMAN		10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? HITE		14. MOTHER'S MAIDEN NAME RACHEL BURGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 716-10-0316	
17. INFORMANT MR. LEROY HITE		RT. #3 HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-26-56 , to 12-31-56 , that I last saw the deceased alive on 12-31-56 , 19 56 , and that death occurred at 7 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE L. W. Curtis III M.D.		ADDRESS (Street, city or town, state) Hagerstown, Md.	
DATE SIGNED 1/2/57			
PHYSICIAN'S NAME (Type) L. W. Curtis III			
22a. BURIAL, CREMATION, or other final disposition (Specify) BURIAL		22b. DATE THEREOF 1/2/57	
22c. NAME OF CEMETERY OR CREMATORY EVERGREEN CEM.		22d. LOCATION (City, town, or county) (State) DUNCANNON PENNA.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		24a. REC'D BY REGISTRAR Jan. 2, 1957	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE Phyllis Bowers	

CERTIFICATE OF DEATH

DECEASED'S NAME JAMES EARL RAY		DATE OF BIRTH JAN 10 1928		PLACE OF BIRTH MOBILE, ALA.	
MARRIAGE MARRIED		DATE OF MARRIAGE JAN 10 1956		PLACE OF MARRIAGE MEMPHIS, TENN.	
OCCUPATION CONGRESSMAN		DATE OF DEATH JAN 4 1968		PLACE OF DEATH MEMPHIS, TENN.	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		DATE OF REPORT JAN 10 1968	
REPORTED BY JAMES EARL RAY		DATE OF REPORT JAN 10 1968		PLACE OF REPORT MEMPHIS, TENN.	
SIGNATURE JAMES EARL RAY		DATE JAN 10 1968		PLACE MEMPHIS, TENN.	
WITNESSES JAMES EARL RAY		DATE JAN 10 1968		PLACE MEMPHIS, TENN.	
DOCTOR'S SIGNATURE JAMES EARL RAY		DATE JAN 10 1968		PLACE MEMPHIS, TENN.	
HOSPITAL MEMPHIS HOSPITAL		DATE JAN 10 1968		PLACE MEMPHIS, TENN.	
CITY MEMPHIS		STATE TENN.		COUNTY SHELBY	
ZIP CODE 38103		FEDERAL BUREAU OF INVESTIGATION WASHINGTON, D.C.		DATE JAN 10 1968	

BUREAU V. B.

JAN 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12971

13019

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <u>Pa.</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Md</u>		c. LENGTH OF STAY IN 1b <u>3 mos. 19 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro, Pa.</u> 75X3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>			d. STREET ADDRESS <u>234 W. 6th St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jennie, Mrs. V. Hockensmith</u>			4. DATE OF DEATH Month Day Year <u>December 20, 1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 5, 1881</u> 75 yrs.	9. AGE (In years last birthday) Months Days Hours Min.	IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mt. Alto, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>CAUFFMAN</u>		
14. MOTHER'S MAIDEN NAME <u>BALDWIN</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident 4 days</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. n. p. m. Month, Day, Year 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 1, 1956 to 20 Dec 1956</u> , that I last saw the deceased alive on <u>19 Dec 1956</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul H. Hark</u> M.D.			*ADDRESS (Street, city or town, State) DATE SIGNED <u>28 W. Potomac Street 20 Dec 56</u>				
PHYSICIAN'S NAME (Type) <u>PAUL HARK, M.D.</u>			<u>Williamsport, Md.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREEN HILL</u>		22d. LOCATION (City, town, or county) (State) <u>WAYNESBORO PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Grove</u>				ADDRESS <u>Grove Waynesboro, Pa</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Emmett McElroy</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Page No. 10

DATE OF DEATH

PLACE OF DEATH

PLACE OF BIRTH

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BUREAU V. S.

DEC 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G209 1-9-57 et

13020

CERTIFICATE OF DEATH

12972
Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> c. LENGTH OF STAY IN 1b <u>15 YEARS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>YOUNG AVENUE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> d. STREET ADDRESS <u>YOUNG AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>MILLARD F. HOLMES</u>				4. DATE OF DEATH Month Day Year <u>DECEMBER - 20 1956</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Approx. 54 yrs.</u>		9. AGE (In years lost birthday) <u>54</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>SAMPLES MANOR WASH. Co MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN W. HOLMES</u>						14. MOTHER'S MAIDEN NAME <u>SUSIE M. GOSNELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-18-1329</u>		17. INFORMANT Address <u>MRS. RIZPAH HOLMES BOONSBORO MD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkins Disease</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>99 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1, 1956</u> , to <u>Dec 20, 1956</u> , that I last saw the deceased alive on <u>Dec 20, 1956</u> , and that death occurred at <u>1 A.M.</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>G. W. LeVan</u> M.D.						ADDRESS (Street, city or town, state) <u>Boonsboro Md.</u>		DATE SIGNED <u>12/21/56</u>	
PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>						22b. DATE THEREOF <u>DEC. 23, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY BOONSBORO WASH. Co MD.</u>				22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>				ADDRESS <u>BOONSBORO MD</u>		24a. REC'D BY REGISTRAR <u>DATE DEC. 23, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John H. East</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

BUREAU V. S.

DEC 31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12973

CERTIFICATE OF DEATH

12973

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PENNA.</u> b. COUNTY <u>FRANKLIN</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WAGERTSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - MERCERSBURG, PA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON Co. Hosp.</u>				d. STREET ADDRESS <u>R. #3</u> <u>75X-3</u>			
3. NAME OF DECEASED (Type or print) First <u>RAY</u> Middle <u>C.</u> Last <u>HOUPT</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 1, 1891</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RURAL MAIL CARRIER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. MAIL</u>		11. BIRTHPLACE (State or foreign country) <u>MERCERSBURG, PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM D. HOUP</u>				14. MOTHER'S MAIDEN NAME <u>SARAH E. TRUAX</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>204-30-5725</u>		17. INFORMANT <u>Paul R. Haupt</u>		Address <u>Mercersburg, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>acute coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary atelectasis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-30 1956</u> , to <u>12-10, 1956</u> , that I last saw the deceased alive on <u>12/10, 1956</u> , and that death occurred at <u>2:45 P. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Hornbaker</u> M.D.				ADDRESS (Street, city or town, state) <u>154 W. Washington St</u> DATE SIGNED <u>12/10/56</u>			
PHYSICIAN'S NAME (Type) <u>JOHN H. HORNBAKER</u>				<u>Hagerstown - Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Dec. 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u>		22d. LOCATION (City, town, or county) (State) <u>MERCERSBURG PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Th. Linniger</u> ADDRESS <u>MERCERSBURG, PA.</u>				24a. REC'D BY REGISTRAR <u>Dec. 13, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13021

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROWNSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROWNSVILLE</u>			
c. LENGTH OF STAY in 1b <u>LIFE</u>				d. STREET ADDRESS <u>MAIN ST.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RACHAEL JENNINGS</u>				4. DATE OF DEATH <u>DECEMBER - 5 - 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>MAY-4-1883</u>		9. AGE (In years last birthday) <u>73-7-1</u> yrs.	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WHEATON WASH. Co. MD. U.S.A.</u>	
13. FATHER'S NAME <u>EPHRAIM BROWN</u>				14. MOTHER'S MAIDEN NAME <u>JESSE MOORE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>CLINTON W. JENNINGS</u> Address <u>BROWNSVILLE MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 yrs</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Arteriosclerotic</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1954</u> , 19 <u>54</u> , to <u>Dec. 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 30</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter H. Shealy</u> M.D.				DATE SIGNED <u>12/5/56</u>			
PHYSICIAN'S NAME (Type) <u>W. H. SHEALY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 7, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. LUKES CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BROWNSVILLE WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u> ADDRESS <u>POONSBORO MD.</u>				24a. REC'D BY REGISTRAR <u>DATE Dec 10/56</u>		24b. REGISTRAR'S SIGNATURE <u>Katherine Sagerhart</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V. S.

DEC 12 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12974

CERTIFICATE OF DEATH

12975

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md</u>				c. LENGTH OF STAY IN 1b <u>30 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>336 Blooms Court</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie May Jones</u>				4. DATE OF DEATH Month Day Year <u>Dec 24 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 9 1889</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Private family</u>		11. BIRTHPLACE (State or foreign country) <u>Brunswick Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Edith Johnson 336 Blooms Court.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic vascular</u> <u>443X</u> DUE TO heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial heart failure grade iv</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	
20f. (City or town) <u>None</u>				20g. (County) <u>None</u>		20h. (State) <u>None</u>	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>Dec. 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 24</u> , 19 <u>56</u> , and that death occurred at <u>3:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D.				ADDRESS (Street, city or town, state) <u>115 N. Potomac Street</u> DATE SIGNED <u>12-27-56</u>			
PHYSICIAN'S NAME (Type) <u>S. Robert Wells, M.D.</u>				Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-29-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R Watson Jr</u>				ADDRESS <u>Hagerstown Md</u>		24a. REC'D BY REGISTRAR <u>Dec 30, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>			

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12975

CERTIFICATE OF DEATH

12976

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>34 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. Co. Hospital</u>				d. STREET ADDRESS <u>BOONSBORO MD. R. 2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>EARL SAMSON KEFAUVER</u>				4. DATE OF DEATH Month Day Year <u>DECEMBER - 12. 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEBRUARY - 5 - 1899</u>	
9. AGE (In years last birthday) <u>57-10-7</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER - HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDER</u>			
11. BIRTHPLACE (State or foreign country) <u>KEEDYSVILLE WASH. Co MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>CHARLES M. KEFAUVER</u>				14. MOTHER'S MAIDEN NAME <u>ANN H. M. POEFFENBERGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-16-3475</u>			
17. INFORMANT <u>MRS. ETHEL M. KEFAUVER</u>				Address <u>BOONSBORO MD. R. 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac dilatation</u> <u>420.1</u> DUE TO <u>Massive pulmonary infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic coronary heart disease</u> DUE TO (c) <u>6 years</u> (6)							INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u> <u>5 days</u> <u>6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>56</u> , to <u>Dec. 12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 12</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u> DATE SIGNED <u>12/14/56</u> ACTUAL SIGNATURE <u>Walter H. Shealy</u> M.D. <u>W</u> PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 16, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u> ADDRESS <u>BOONSBORO MD.</u>				24a. REC'D BY REGISTRAR <u>Dec. 18, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Robert H. Powers</u>	

BUREAU V. S.

DEC 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12977 CERTIFICATE OF DEATH

12979

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u>			
c. LENGTH OF STAY IN 1b <u>4 Mo.</u>				d. STREET ADDRESS <u>N. Carlisle St. Ext</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Billie</u> Middle <u>May</u> Last <u>Kendall</u>				4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 30, 1874</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> Hours <u>56</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>John W. Mummert</u>			
14. MOTHER'S MAIDEN NAME <u>Annie Myers</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mr. Clyde Kendall, Greencastle, Pa</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X</u> DUE TO <u>Carcinoma Stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>6 mo</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>10-1-</u> , 19 <u>56</u> , to <u>12-3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 3-56</u> , 19 <u>56</u> , and that death occurred at <u>26</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. E. W. Smith</u>				ADDRESS (Street, city or town, state) <u>Hagerstown Md</u> DATE SIGNED <u>12/4/56</u>			
PHYSICIAN'S NAME (Type) <u>J. E. W. Smith</u>				M.D. <u>Hagerstown Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/6/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle Franklin Co. Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald M. Zimmerman</u>				ADDRESS <u>Greencastle, Pa</u>		24a. REC'D BY REGISTRAR <u>Dec 7, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Phyllis Bowers</u>							

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12980
312

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEAR BOONSBORO RURAL</u> c. LENGTH OF STAY IN 1b <u>9 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BOONSBORO MD.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEAR BOONSBORO RURAL</u> d. STREET ADDRESS <u>BOONSBORO MD.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELMER</u> Middle <u>A.</u> Last <u>KEPHART</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>-6-</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/> <u>JANUARY-2-1894</u>			
9. AGE (In years last birthday) <u>62-11-4</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>FREDERICK COUNTY MARYLAND</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TENANT</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>LUTHER A. KEPHART</u>				14. MOTHER'S MAIDEN NAME <u>ADIE FORD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-36-2398</u>		17. INFORMANT <u>MRS. PERCY ALBERT JR.</u> Address <u>BOONSBORO MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebral hemorrhage</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive coronary heart disease</u> (c), stating the underlying cause last. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial asthma</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>none</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>			
20f. (City or town) <u>-</u>		(County) <u>-</u>		(State) <u>-</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				DATE SIGNED <u>12-7-56</u>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M. D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 9, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>			
22d. LOCATION (City, town, or county) <u>BOONSBORO</u>		(State) <u>WASH. CO. MD.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>PAST FUNERAL HOME</u>				24a. REC'D BY REGISTRAR <u>DATE 12/11/56</u>			
ADDRESS <u>BOONSBORO MD</u>				24b. REGISTRAR'S SIGNATURE <u>RA Greeting</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAINE AND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: _____
AGE: _____ SEX: _____
DATE OF DEATH: _____
PLACE OF DEATH: _____

CAUSE OF DEATH: _____
MANNER OF DEATH: _____

DATE OF EXAMINATION: _____
PLACE OF EXAMINATION: _____

SIGNATURE OF EXAMINER: _____
TITLE: _____

DATE OF SIGNATURE: _____
PLACE OF SIGNATURE: _____

DATE OF DEATH: _____
PLACE OF DEATH: _____

DATE OF EXAMINATION: _____
PLACE OF EXAMINATION: _____

SIGNATURE OF EXAMINER: _____
TITLE: _____

DATE OF SIGNATURE: _____
PLACE OF SIGNATURE: _____

DATE OF DEATH: _____
PLACE OF DEATH: _____

DATE OF EXAMINATION: _____
PLACE OF EXAMINATION: _____

SIGNATURE OF EXAMINER: _____
TITLE: _____

DATE OF SIGNATURE: _____
PLACE OF SIGNATURE: _____

DATE OF DEATH: _____
PLACE OF DEATH: _____

DATE OF EXAMINATION: _____
PLACE OF EXAMINATION: _____

SIGNATURE OF EXAMINER: _____
TITLE: _____

DATE OF SIGNATURE: _____
PLACE OF SIGNATURE: _____

BUREAU V. S.

DEC 13 1956

RECEIVED

RECEIVED

12976

CERTIFICATE OF DEATH

Dr Hoacklander

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 16 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 118 West Wilson Blvd				d. STREET ADDRESS 118 West Wilson Blvd			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HOWARD Middle CLAYTON Last KEPLINGER				4. DATE OF DEATH Month Dec Day 20 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 27 1887	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture Inspector		10b. KIND OF BUSINESS OR INDUSTRY Statton Co		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Keplinger				14. MOTHER'S MAIDEN NAME Sabina Palmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-6923		17. INFORMANT Mrs Lona E. Keplinger Address 118 W. Wilson Blvd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) Hypertension				INTERVAL BETWEEN ONSET AND DEATH 72 hrs 2 yrs ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 19 1956 , to Dec 20 1956 , that I last saw the deceased alive on Jan 19 1956 , and that death occurred at 9:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE E. Edgar B. Goodrich M.D.				ADDRESS (Street, city or town, state) Hagerstown Md DATE SIGNED 12/21/56			
PHYSICIAN'S NAME (Type) E. Edgar B. Goodrich							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/23/56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Dec 24 1956	
				24b. REGISTRAR'S SIGNATURE Charles H. Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

1956

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. HARRIS		68		M		W		1888		NEW YORK	
MARRIAGE		DATE		PLACE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MARRIED		1910		NEW YORK		1956		NEW YORK		HEART DISEASE	
OCCUPATION		DATE		PLACE		DATE OF INTERMENT		PLACE OF INTERMENT		DATE OF BURIAL	
RETIRED		1945		NEW YORK		1956		NEW YORK		1956	
EDUCATION		DATE		PLACE		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF FILING	
HIGH SCHOOL		1905		NEW YORK		1956		NEW YORK		1956	
MILITARY SERVICE		DATE		PLACE		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF FILING	
NONE		1910		NEW YORK		1956		NEW YORK		1956	
PREVIOUS DEATHS		DATE		PLACE		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF FILING	
NONE		1910		NEW YORK		1956		NEW YORK		1956	
PREVIOUS DEATHS		DATE		PLACE		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF FILING	
NONE		1910		NEW YORK		1956		NEW YORK		1956	

BUREAU V. S.

DEC 27 1956

RECEIVED

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. HARRIS		68		M		W		1888		NEW YORK	
MARRIAGE		DATE		PLACE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MARRIED		1910		NEW YORK		1956		NEW YORK		HEART DISEASE	
OCCUPATION		DATE		PLACE		DATE OF INTERMENT		PLACE OF INTERMENT		DATE OF BURIAL	
RETIRED		1945		NEW YORK		1956		NEW YORK		1956	
EDUCATION		DATE		PLACE		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF FILING	
HIGH SCHOOL		1905		NEW YORK		1956		NEW YORK		1956	
MILITARY SERVICE		DATE		PLACE		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF FILING	
NONE		1910		NEW YORK		1956		NEW YORK		1956	
PREVIOUS DEATHS		DATE		PLACE		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF FILING	
NONE		1910		NEW YORK		1956		NEW YORK		1956	

12978

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>4 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Cty. Hospital</u>				d. STREET ADDRESS <u>134 East. Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John Augustus</u> Middle <u>Knode</u> Last <u>Knode</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 2, 1889</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Clearspring, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred Knode</u>				14. MOTHER'S MAIDEN NAME <u>Martha Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <input checked="" type="checkbox"/> War I <u> </u>				16. SOCIAL SECURITY NO. <u>219-14-8200</u>		17. INFORMANT <u>Robert Kerfoot, 134 East. Ave</u> Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic myocardial heart disease</u> DUE TO <u>acute myocardial failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>422.1</u> (b) <u> </u> DUE TO <u> </u> (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes M</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>None</u> 19 p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>Nov. 29</u> , 19 <u>56</u> , to <u>Dec. 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 2</u> , 19 <u>56</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D.				ADDRESS (Street, city or town, state) <u>115 N. Potomac Street</u> DATE SIGNED <u>12-3-56</u>			
PHYSICIAN'S NAME (Type) <u>S. Robert Wells, M.D.</u>				<u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 5, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Clearspring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>Dec. 6, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Paul H. Bowser</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. SIGNATURE OF PHYSICIAN [Illegible]	
10. SIGNATURE OF REGISTRAR [Illegible]		11. SIGNATURE OF WITNESS [Illegible]		12. SIGNATURE OF SECOND WITNESS [Illegible]	
13. SIGNATURE OF THIRD WITNESS [Illegible]		14. SIGNATURE OF FOURTH WITNESS [Illegible]		15. SIGNATURE OF FIFTH WITNESS [Illegible]	
16. SIGNATURE OF SIXTH WITNESS [Illegible]		17. SIGNATURE OF SEVENTH WITNESS [Illegible]		18. SIGNATURE OF EIGHTH WITNESS [Illegible]	
19. SIGNATURE OF NINTH WITNESS [Illegible]		20. SIGNATURE OF TENTH WITNESS [Illegible]		21. SIGNATURE OF ELEVENTH WITNESS [Illegible]	
22. SIGNATURE OF TWELFTH WITNESS [Illegible]		23. SIGNATURE OF THIRTEENTH WITNESS [Illegible]		24. SIGNATURE OF FOURTEENTH WITNESS [Illegible]	
25. SIGNATURE OF FIFTEENTH WITNESS [Illegible]		26. SIGNATURE OF SIXTEENTH WITNESS [Illegible]		27. SIGNATURE OF SEVENTEENTH WITNESS [Illegible]	
28. SIGNATURE OF EIGHTEENTH WITNESS [Illegible]		29. SIGNATURE OF NINETEENTH WITNESS [Illegible]		30. SIGNATURE OF TWENTIETH WITNESS [Illegible]	
31. SIGNATURE OF TWENTY-FIRST WITNESS [Illegible]		32. SIGNATURE OF TWENTY-SECOND WITNESS [Illegible]		33. SIGNATURE OF TWENTY-THIRD WITNESS [Illegible]	
34. SIGNATURE OF TWENTY-FOURTH WITNESS [Illegible]		35. SIGNATURE OF TWENTY-FIFTH WITNESS [Illegible]		36. SIGNATURE OF TWENTY-SIXTH WITNESS [Illegible]	
37. SIGNATURE OF TWENTY-SEVENTH WITNESS [Illegible]		38. SIGNATURE OF TWENTY-EIGHTH WITNESS [Illegible]		39. SIGNATURE OF TWENTY-NINTH WITNESS [Illegible]	
40. SIGNATURE OF THIRTIETH WITNESS [Illegible]		41. SIGNATURE OF THIRTY-FIRST WITNESS [Illegible]		42. SIGNATURE OF THIRTY-SECOND WITNESS [Illegible]	
43. SIGNATURE OF THIRTY-THIRD WITNESS [Illegible]		44. SIGNATURE OF THIRTY-FOURTH WITNESS [Illegible]		45. SIGNATURE OF THIRTY-FIFTH WITNESS [Illegible]	
46. SIGNATURE OF THIRTY-SIXTH WITNESS [Illegible]		47. SIGNATURE OF THIRTY-SEVENTH WITNESS [Illegible]		48. SIGNATURE OF THIRTY-EIGHTH WITNESS [Illegible]	
49. SIGNATURE OF THIRTY-NINTH WITNESS [Illegible]		50. SIGNATURE OF FORTY WITNESS [Illegible]		51. SIGNATURE OF FORTY-FIRST WITNESS [Illegible]	
52. SIGNATURE OF FORTY-SECOND WITNESS [Illegible]		53. SIGNATURE OF FORTY-THIRD WITNESS [Illegible]		54. SIGNATURE OF FORTY-FOURTH WITNESS [Illegible]	
55. SIGNATURE OF FORTY-FIFTH WITNESS [Illegible]		56. SIGNATURE OF FORTY-SIXTH WITNESS [Illegible]		57. SIGNATURE OF FORTY-SEVENTH WITNESS [Illegible]	
58. SIGNATURE OF FORTY-EIGHTH WITNESS [Illegible]		59. SIGNATURE OF FORTY-NINTH WITNESS [Illegible]		60. SIGNATURE OF FIFTY WITNESS [Illegible]	

BUREAU V. 8

DEC 10 1956

RECEIVED

Andrew K. Collins, Hagerstown, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12979

CERTIFICATE OF DEATH

Reg. Dist. No. 12982
302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>559 Salem Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>SCOTT</u> Last <u>LAKE</u>				4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1886</u>	9. AGE (In years lost birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>25</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical Contr.</u>		11. BIRTHPLACE (State or foreign country) <u>Fulton County, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ephriam Lake</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Harr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-16-1243</u>		17. INFORMANT Address <u>Mrs. Paul W. Grimm Hagerstown, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary insufficiency</u> (c) <u>Coronary arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>2 hrs.</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 24</u> , 19 <u>56</u> , to <u>Dec. 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 24</u> , 19 <u>56</u> , and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dalton M. Welty / O. D. Spence</u> M.D.				ADDRESS (Street, city or town, state) <u>998 Potomac Ave. Hagerstown, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Dalton M. Welty, M.D.</u>				DATE SIGNED <u>Dec. 26, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/18/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Ronger</u> ADDRESS <u>Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>Dec. 26, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>B. H. Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

1956

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1921		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		HABIT		TENDENCY	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		DRIVER		SMOKER		NONE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
APR 4 1968		MEMPHIS		SHOOTING		HOMICIDE		HEART DISEASE		BLOOD LOSS		SURGERY		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF DISTRICT ATTORNEY		SIGNATURE OF SHERIFF		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968	

BUREAU V. 2

DEC 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

item 3:G210-1-8-571

12980 CERTIFICATE OF DEATH

Reg. Dist. No.

12982

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 31 1/2 East Franklin St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edgar Daniel Lambert				4. DATE OF DEATH December 28 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 11, 1887 69 yrs.	
9. AGE (In years last birthday) 69		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (State or foreign country) Downsville Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME George S. Lambert		14. MOTHER'S MAIDEN NAME Hallie McClure			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. 220-30-9823		17. INFORMANT Mrs. Ethel F. Lambert Address Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Dissecting Aneurysm of Abdominal Aorta 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 months 5 years -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec. 12 , 19 56 , to Dec. 28 , 19 56 , that I last saw the deceased alive on Dec. 28 , 19 56 , and that death occurred at 4:53 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE George Jennings				ADDRESS (Street, city or town, state) 136 W. Washington St. Hagerstown, Ind.			
PHYSICIAN'S NAME (Type) George Jennings				DATE SIGNED 12/29/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-56		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown Md.		24. REC'D BY REGISTRAR Jan. 2, 1957	
				24b. REGISTRAR'S SIGNATURE Phyllis H. Bowers			

20 years

16214

REVIST

• Townsville

520 30-0828 Mrs. Rachel V. Janssen

BUREAU V. S.

JAN 4 1957

RECEIVED

Reg. Dist. No.

13023

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HANCOCK</u>		c. LENGTH OF STAY IN 1b <u>34 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Agnes</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>18</u> Year <u>1956</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Sept 30 1870</u>	
8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>86</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Fulton Co, Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hendershot</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Dickey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Clifford Miller Hancock MD</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Cerebral Hemorrh.</u> DUE TO <u>arteriosclerosis</u> (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 17, 1956</u> , to <u>Dec 18, 1956</u> , that I last saw the deceased alive on <u>Dec 17, 1956</u> , and that death occurred at <u>—</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L.M. Shaffer</u> M.D.		ADDRESS (Street, city or town, state) <u>Hancock, Md.</u> DATE SIGNED <u>12/18/56</u>	
PHYSICIAN'S NAME (Type) <u>L.M. SHAFFER M.D.</u>		<u>HANCOCK, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 20, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mays Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Wardensburg, Fulton Co, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Hines</u> ADDRESS <u>Harrisonville Pa</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>12/18/56</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		24c. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JANUARY 15, 1956	
AGE		SEX	
65		Male	
RACE		EDUCATION	
White		High School	
OCCUPATION		RESIDENCE	
Retired		1234 Main St., Baltimore, Md.	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
IMMEDIATE CAUSE		FUNDAMENTAL CAUSE	
Myocardial Infarction		Atherosclerosis	
DATE OF REPORT		REPORTED BY	
JANUARY 16, 1956		J. H. HARRIS	
SIGNATURE OF REPORTER		SIGNATURE OF PHYSICIAN	
[Signature]		[Signature]	
DATE OF DEATH		PLACE OF DEATH	
JANUARY 15, 1956		Home	

BUREAU V. 1

DEC 20 1956

RECEIVED

13024

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>Fabbaus</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>Fabbaus</u>			
c. LENGTH OF STAY IN 1b <u>7 years</u>				d. STREET ADDRESS <u>Hagerston Md. R.F.D.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hagerston Md. R.F.D.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William D.</u> Middle <u>Lankford</u> Last <u>Lankford</u>				4. DATE OF DEATH <u>December 17</u> 19 <u>56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cubito</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 10 1866</u>	
9. AGE (In years last birthday) <u>90-4-7</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer - Factory - Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Waynesboro Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>	
13. FATHER'S NAME <u>George Lankford</u>				14. MOTHER'S MAIDEN NAME <u>Amanda</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Lucille Kennedy</u> Address <u>Hagerston R.F.D. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/16/56</u> 19 <u>56</u> to <u>12/17/56</u> 19 <u>56</u> , that I last saw the deceased alive on <u>12/17/56</u> 19 <u>56</u> , and that death occurred at <u>11:17</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph F. Young</u> M.D.				ADDRESS (Street, city or town, state) <u>William Lankford, Md.</u> DATE SIGNED <u>12/18/56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 20 - 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerston Wash. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>East Funeral Home</u> ADDRESS <u>Beenshaw Md.</u>				24a. REC'D BY REGISTRAR <u>DATE Dec 18, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John P. Bart.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>George Franklin</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>1910-10-10</i></p>	
<p>5. PLACE OF BIRTH <i>Frederick, Md.</i></p>		<p>6. OCCUPATION <i>Frederick, Md.</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF DEATH <i>1956-12-21</i></p>	
<p>9. CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>10. PLACE OF DEATH <i>Frederick, Md.</i></p>	
<p>11. SIGNATURE OF PHYSICIAN <i>George Franklin</i></p>		<p>12. SIGNATURE OF REGISTRAR <i>George Franklin</i></p>	

BUREAU V. 2

DEC 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12981

CERTIFICATE OF DEATH

Reg. Dist. No.

12986
302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>MT. LENA RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				d. STREET ADDRESS <u>BOONSBORO MD</u>			
3. NAME OF DECEASED (Type or print) <u>DOUGLAS DEWAYNE LEFEVER</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DECEMBER 20 - 1956</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>HAGERSTOWN WASH. CO MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>SHIRLEY ANN LEFEVER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>SHIRLEY A. LEFEVER</u> Address <u>BOONSBORO MD. R2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776 X Prematurity</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>12/20</u> , 19 <u>56</u> , to <u>12/20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/20</u> , 19 <u>56</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D. J. Moyer</u>				DATE SIGNED <u>12/26/56</u>			
PHYSICIAN'S NAME (Type) <u>D. J. Moyer, M. D.</u>				ADDRESS (Street, city or town, state) <u>135 N. Pot. St., Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Dec. 24, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PAST FUNERAL HOME</u>				ADDRESS <u>BOONSBORO MD</u>		24a. REC'D BY REGISTRAR <u>Dec 29, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Blanch Bowers</u>							

2081171XVO

CERTIFICATE OF DEATH

NAME OF DECEASED WAYLAND		PLACE OF BIRTH WAYLAND	
DATE OF BIRTH JAN 2 1957		PLACE OF DEATH WAYLAND	
SEX M		RACE W	
OCCUPATION STUDENT		CAUSE OF DEATH ...	
SIGNATURE OF DECEASED ...		SIGNATURE OF PHYSICIAN ...	
SIGNATURE OF WITNESS ...		SIGNATURE OF REGISTRAR ...	

BUREAU V. S.

JAN 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13025 **CERTIFICATE OF DEATH**

12987

Reg. Dist. No. **204**

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Md c. LENGTH OF STAY IN 1b 43 Yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Maryland. d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First William Middle Sherman Last Leighty				4. DATE OF DEATH Month 12 Day 24 Year 19 56									
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 5.15.1876		9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR: Months 7 Days 8 Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Buisness				10b. KIND OF BUSINESS OR INDUSTRY Taxi Buisness				11. BIRTHPLACE (State or foreign country) Bedford County Penna		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Leighty						14. MOTHER'S MAIDEN NAME Eliza Minnick							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. _____				17. INFORMANT Elizabeth Sellers Robinsville Penna. Address _____					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Cerebral Thrombosis DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH 1 day 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I attended the deceased from Dec 23, 19 56 , to Dec 23, 19 56 , that I last saw the deceased alive on Dec 23, 19 56 , and that death occurred at 2.4 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12.27.56 SIGNED _____ ACTUAL SIGNATURE John Wilson M.D. W. Main St, Hancock MD. PHYSICIAN'S NAME (Type) John Wilson W. Main St. Hancock Md.													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12.27.56		22c. NAME OF CEMETERY OR CREMATORY Robinsville Cemetery				22d. LOCATION (City, town, or county) Bedford Bedford Penna. (State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE Howard K Stone Hancock Md. ADDRESS _____						24a. REC'D BY REGISTRAR DATE 12/27		24b. REGISTRAR'S SIGNATURE HT Keller					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

CERTIFICATE OF DEATH

REG. NO. 100

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

AGE

SEX

SEX

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 13026 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

12988

Reg. Dist. No. 365

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u> 10X.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fahrney-Keedy Home for Aged</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lorenzo Carlton Lighter</u>				4. DATE OF DEATH Month Day Year <u>12 20 19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/15/1874</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John H. Lighter</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Kepler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. John Englebrecht, Frederick, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosed arterio sclerosis -</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Haemorrhage</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 yrs</u> <u>2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1</u> , 19 <u>55</u> , to <u>Dec 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>56</u> , and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. W. Lillan</u> M.D.				ADDRESS (Street, city or town, state) <u>Boonsboro</u> DATE SIGNED <u>12/21/56</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Gerald LeVan</u>				<u>Boonsboro, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/23/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Gladhill Co., Middletown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Dec. 23. 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Baird</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12990

13027

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FUNKSTOWN</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST.</u>				d. STREET ADDRESS <u>FUNKSTOWN</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEWIS CLINTON MCCOY</u>				4. DATE OF DEATH Month Day Year <u>DECEMBER - 3 - 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT-9-1872</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED COOPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BARRELL MFG.</u>		11. BIRTHPLACE (State or foreign country) <u>FUNKSTOWN WASH. Co. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THEODORE F. MCCOY</u>				14. MOTHER'S MAIDEN NAME <u>ROSA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>LEWIS R. MCCOY FUNKSTOWN WASH. Co. MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease.</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH Years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>Oct. 10, 1945</u> , to <u>Dec. 3, 1956</u> , that I lost saw the deceased alive on <u>December 3, 1956</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. A. Bell</u>				ADDRESS (Street, city or town, state) <u>119 N. Potomac Street, Hagerstown, Maryland.</u>			
DATE SIGNED <u>12-4-56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 5, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FUNKSTOWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FUNKSTOWN WASH. Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>				ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR <u>Dec. 10, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA		CONTRACTOR	
MARRIAGE		DATE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		OCCUPATION AT DEATH		CAUSE OF DEATH	
MARRIED		JAN 15 1950		JAN 6 1968		MEMPHIS, TENNESSEE		CONTRACTOR		HEART DISEASE	
PREVIOUS MARRIAGES		DATE OF PREVIOUS MARRIAGE		DATE OF PREVIOUS DEATH		PLACE OF PREVIOUS DEATH		OCCUPATION AT PREVIOUS DEATH		CAUSE OF PREVIOUS DEATH	
NONE		NONE		NONE		NONE		NONE		NONE	
EDUCATION		SCHOOLING		SCHOOLING		SCHOOLING		SCHOOLING		SCHOOLING	
HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL	
UNIVERSITY		UNIVERSITY		UNIVERSITY		UNIVERSITY		UNIVERSITY		UNIVERSITY	
COLLEGE		COLLEGE		COLLEGE		COLLEGE		COLLEGE		COLLEGE	
POSTGRADUATE		POSTGRADUATE		POSTGRADUATE		POSTGRADUATE		POSTGRADUATE		POSTGRADUATE	
NONE		NONE		NONE		NONE		NONE		NONE	
RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION	
METHODIST		METHODIST		METHODIST		METHODIST		METHODIST		METHODIST	
OTHER		OTHER		OTHER		OTHER		OTHER		OTHER	
NONE		NONE		NONE		NONE		NONE		NONE	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL	
ACCIDENT		ACCIDENT		ACCIDENT		ACCIDENT		ACCIDENT		ACCIDENT	
SUICIDE		SUICIDE		SUICIDE		SUICIDE		SUICIDE		SUICIDE	
HOMICIDE		HOMICIDE		HOMICIDE		HOMICIDE		HOMICIDE		HOMICIDE	
OTHER		OTHER		OTHER		OTHER		OTHER		OTHER	
NONE		NONE		NONE		NONE		NONE		NONE	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
HOME		HOME		HOME		HOME		HOME		HOME	
HOSPITAL		HOSPITAL		HOSPITAL		HOSPITAL		HOSPITAL		HOSPITAL	
OTHER		OTHER		OTHER		OTHER		OTHER		OTHER	
NONE		NONE		NONE		NONE		NONE		NONE	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
JAN 6 1968		JAN 6 1968		JAN 6 1968		JAN 6 1968		JAN 6 1968		JAN 6 1968	
TIME OF DEATH		TIME OF DEATH		TIME OF DEATH		TIME OF DEATH		TIME OF DEATH		TIME OF DEATH	
10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
HOME		HOME		HOME		HOME		HOME		HOME	
HOSPITAL		HOSPITAL		HOSPITAL		HOSPITAL		HOSPITAL		HOSPITAL	
OTHER		OTHER		OTHER		OTHER		OTHER		OTHER	
NONE		NONE		NONE		NONE		NONE		NONE	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
JAN 6 1968		JAN 6 1968		JAN 6 1968		JAN 6 1968		JAN 6 1968		JAN 6 1968	
TIME OF DEATH		TIME OF DEATH		TIME OF DEATH		TIME OF DEATH		TIME OF DEATH		TIME OF DEATH	
10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12982

CERTIFICATE OF DEATH

12991
Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>			d. STREET ADDRESS <u>951 D Main Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Vicky Dianne McNabb</u>			4. DATE OF DEATH Month <u>December</u> Day <u>10</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 5, '56</u>		9. AGE (In years lost birthday) yrs. <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Billy Joe McNabb, Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Alice Louisa Neff</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Billy Joe McNabb Sr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>751x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Meningeal spine (tumor)</u> (c) <u>Congestive</u>			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>o. 11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-5-56</u> , 19 <u>56</u> , to <u>12-10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-9-56</u> , 19 <u>56</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Hagerstown Md</u>		DATE SIGNED <u>12/10/56</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 12, '56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Broadfording Cem.</u>	
				22d. LOCATION (City, town, or county) (State) <u>Broadfording Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Williamsport, Md</u>		24a. REC'D BY REGISTRAR <u>Dec. 12, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13028 CERTIFICATE OF DEATH

12992

Reg. Dist. No.

301

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>50 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>116 N. Conococheague</u>				d. STREET ADDRESS <u>116 N. Conococheague</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA Ellen Miller</u>				4. DATE OF DEATH Month Day Year <u>Dec. 1 1956</u>			
5. SEX <u>F. male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1873</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Curwensville, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel S. Moore</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Cauldwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Bessie Wilson New Orleans, La.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/30/56</u> 19, to <u>12/1/56</u> 19, that I last saw the deceased alive on <u>12/1/56</u> 19, and that death occurred at <u>10:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Ralph F. Young</u>		M.D.		ADDRESS (Street, city or town, state) <u>Williamsport, Md.</u>		DATE SIGNED <u>12/3/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 4, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles X. [unclear]</u>				ADDRESS <u>Williamsport, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Dec. 3, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>E. Lee McElroy</u>			

BUREAU V. S.

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RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12993

CERTIFICATE OF DEATH

Reg. Dist. No. 302

12983

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		STATE <u>Md.</u>		COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>5 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Robinwood Drive</u>				STREET ADDRESS (If rural give location) <u>Robinwood Drive</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ELLIS</u>		(Middle) <u>BRINTON</u>		(Last) <u>MILLER</u>		(Month) <u>12-3-56</u> (Day) <u>19</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-4-1917</u>	9. AGE last birthday <u>39</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Leather Ind.</u>		11. BIRTHPLACE (State or foreign country) <u>Mercersburg, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ellis Brady Miller</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Sharar</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>WW2 & Korean</u>		16. SOCIAL SECURITY NO. <u>209-10-3907</u>		17. INFORMANT & ADDRESS <u>Robinson Dr., Mrs. Va. B. Miller, Hagt. Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Carcinoma of Brain</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>metastasis from Lung</u>						<u>6 mo</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-15-56</u> to <u>12-3-56</u>, 19....., that I last saw the deceased alive on <u>12/2</u>, 19....., and that death occurred at <u>3 A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Paul Harrison M.D.</u>				ADDRESS (Street, city, town, state) <u>318 N, Potomac St., Hagerstown Md. 12-3-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-5-56</u>		NAME OF CEMETERY OR CREMATORY <u>Fairview Ce.</u>		LOCATION (City, town, or county) (State) <u>Mercersburg, Pa.</u>	
24. REC'D BY REGISTRAR <u>Dec 5, 1956</u>		REGISTRAR'S SIGNATURE <u>Blasf. Rogers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J.M. Springer</u>		ADDRESS <u>Mercersburg, Pa.</u>	

CERTIFICATE OF DEATH

Case No. 12

1. NAME (Last, first, middle, and initial)

2. SEX (Male or Female)

3. AGE (Years, months, and days)

4. BIRTH DATE (Month, day, and year)

5. BIRTH PLACE (City, State, and Country)

6. DEATH DATE (Month, day, and year)

7. DEATH TIME (Hour and minute)

8. DEATH PLACE (City, State, and Country)

9. CAUSE OF DEATH (Immediate cause)

10. CAUSE OF DEATH (Underlying cause)

11. CAUSE OF DEATH (Contributing cause)

12. SIGNATURE (Physician)

13. SIGNATURE (Medical Examiner)

14. SIGNATURE (Coroner)

15. SIGNATURE (Registrar)

16. SIGNATURE (Witness)

17. SIGNATURE (Witness)

18. SIGNATURE (Witness)

19. SIGNATURE (Witness)

20. SIGNATURE (Witness)

21. SIGNATURE (Witness)

22. SIGNATURE (Witness)

BUREAU V. 1

DEC 7 1956

RECEIVED

12984

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>18 1/2 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>20 ROESSNER AVE</u>				d. STREET ADDRESS <u>20 ROESSNER AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>GARDNER B. MILLER</u>				4. DATE OF DEATH Month Day Year <u>DECEMBER - 25 - 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DECEMBER - 5 - 1894</u>	
9. AGE (In years last birthday) <u>62-0-27</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>		11. BIRTHPLACE (State or foreign country) <u>FAIRPLAY WASH. CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>DAVID MILLER</u>		14. MOTHER'S MAIDEN NAME <u>ANNA PATTISON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>MRS. MARY MILLER</u>		Address <u>20 ROESSNER AVE HAGERSTOWN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/25/56</u> , 19 <u>56</u> , to <u>12/25/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/25/56</u> , 19 <u>56</u> , and that death occurred at <u>7:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Ralph F. Young M.D.</u> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 28, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PAST FUNERAL HOME</u>				ADDRESS <u>BOONSBORO MD</u>		24a. REC'D BY REGISTRAR <u>Dec. 29, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Blair H. Bowers</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		WHITE		JAN 5, 1928		MEMPHIS, TENN.	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF DEATH		11. DATE OF DEATH		12. TIME OF DEATH	
MEMBER OF CONGRESS		SHOOTING		SUICIDE		MEMPHIS, TENN.		APR 4, 1968		4:00 PM	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF CLERK		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF JUDGE	

BUREAU V. S.

RECEIVED

JAN 2 1957

19. SIGNATURE OF DECEASED

20. SIGNATURE OF WITNESS

21. SIGNATURE OF PHYSICIAN

22. SIGNATURE OF CLERK

23. SIGNATURE OF REGISTRAR

24. SIGNATURE OF JUDGE

12985

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				d. STREET ADDRESS <u>218 Mealey Pkwy.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Lawrence</u> Last <u>Miller</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-1881</u>	9. AGE (In years last birthday) <u>75 yrs.</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>24</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hallack Gill Lawrence</u>				14. MOTHER'S MAIDEN NAME <u>Laura V. Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Isabel Miller, Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Juvenile due to obstruction of common duct, GI bleeding</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 Sept</u> , 19 <u>56</u> , to <u>11 Dec</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11 Dec 56</u> , 19 <u>56</u> , and that death occurred at <u>9:40 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Richard T. Binford</u> M.D. ADDRESS (Street, city or town, state) <u>1135 Potomac Ave, Hagerstown</u> DATE SIGNED <u>11 Dec 56</u> PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD</u> <u>1135 POTOMAC AVE., HAGERSTOWN, MARYLAND.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/14/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wolf's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dilliner, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Houzer Funeral Home</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Dec 15, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Robert H. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

CERTIFICATE OF DEATH

Dr Ditto Jr.

Reg. Dist. No.

13029

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 2				c. LENGTH OF STAY IN 1b 6 Mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Conv Home				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AMOS Middle EZEKIAL Last MOWEN				4. DATE OF DEATH Month Dec Day 21 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 10 1871		9. AGE (In years last birthday) 85	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) near Fairview Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Mowen				14. MOTHER'S MAIDEN NAME Lousiana Wilkes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-16-1909		17. INFORMANT Address John E. Mowen Maugansville Md Box174			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Face 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-1-56 , 19 56 , to 12-21 , 19 56 , that I last saw the deceased alive on 12-20-56 , 19 56 , and that death occurred at 5:42 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE H. W. Smith M.D. Hagerstown Md 12/21/56 PHYSICIAN'S NAME (Type) H. W. Smith							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/23/56		22c. NAME OF CEMETERY OR CREMATORY Dunkard Cemetery		22d. LOCATION (City, town, or county) (State) Broadfording Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR DEC 26 1956		24b. REGISTRAR'S SIGNATURE Chris Linder	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13030

CERTIFICATE OF DEATH

12997

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN				c. LENGTH OF STAY IN 1b I DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CLEAR SPRING X			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS INDIAN SPRINGS			
3. NAME OF DECEASED (Type or print) First JOHN Middle HENRY Last MUMMERT				4. DATE OF DEATH Month 12 Day 17 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 18, 1884	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 12 Days 17 Hours 19 Min. 56		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LABORER		10b. KIND OF BUSINESS OR INDUSTRY GENERAL LABOR	
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN MUMMERT				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-18-9470		17. INFORMANT MRS. BESSIE MUMMERT Address CLEAR SPRING RT 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Arterial Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5-yr. (c) 24 hours						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec. 16, 1956 to Dec. 17, 1956 , that I last saw the deceased alive on Dec. 17, 1956 , and that death occurred at 11:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Clear Spring Md. DATE SIGNED 12/19/56							
ACTUAL SIGNATURE David R. Brewer M.D.				PHYSICIAN'S NAME (Type) David R. Brewer Clear Spring Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/20/56		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		22d. LOCATION (City, town, or county) (State) CLEAR SPRING MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark ADDRESS Clear Spring, Md.				24a. REC'D BY REGISTRAR Dec. 22, 1956		24b. REGISTRAR'S SIGNATURE Chas H. Boover	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES H. HARRIS		M		45		1910		BALTIMORE, MARYLAND		LABORER		MARRIED		WHITE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
DEC 26 1956		10:30 PM		HOME		HEART DISEASE		NATURAL		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
17. COUNTY		18. CITY		19. STATE		20. ZIP CODE		21. REGISTRAR'S OFFICE		22. REGISTRAR'S NAME		23. REGISTRAR'S ADDRESS		24. REGISTRAR'S PHONE	
BALTIMORE		BALTIMORE		MARYLAND		21201		BALTIMORE, MARYLAND		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

DEC 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G208 12-26-56 et

12999
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Walkersville	
c. LENGTH OF STAY IN 1b 27 days		d. STREET ADDRESS 10 X - 2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth (NMN) Middle Nelson Last Nelson		4. DATE OF DEATH Month Dec. Day 15 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 7 Days 15 Hours 19 Min. 56	IF UNDER 24 HRS. Months 7 Days 15 Hours 19 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Rural - Walkersville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert J. Nelson		14. MOTHER'S MAIDEN NAME Annie Englar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	
17. INFORMANT Kent C. Nicodemus - Walkersville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured ribs DUE TO Conditions, if any, which gave rise to immediate cause (b) Ruptured spleen & omentum (c), stating the underlying cause last. hemorrhage & shock DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death: 27 days			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in automobile, collision	
20c. TIME OF INJURY Month, Day, Year Nov. 19 1956 Hour 4:30 P. M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. #40		20f. (City or town) (County) (State) Boonsboro Wash. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Dec. 16 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-19-56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Frederick, Fred., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. C. Barton		ADDRESS Walkersville, Md.	
24a. REC'D BY REGISTRAR Dec. 17, 1956		24b. REGISTRAR'S SIGNATURE W. H. Bowers	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File-pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED LAST FIRST MIDDLE SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		AGE YEARS MONTHS DAYS	
PLACE OF BIRTH STATE OF MARYLAND		DATE OF BIRTH YEAR MONTH DAY	
OCCUPATION TRADE OR PROFESSION		PLACE OF DEATH HOME HOSPITAL	
CAUSE OF DEATH DISEASE OR INJURY		MANNER OF DEATH ACCIDENT SUICIDE	
TIME OF DEATH HOUR MINUTE		DATE OF DEATH YEAR MONTH DAY	
SIGNATURE OF MEDICAL EXAMINER TITLE		SIGNATURE OF WITNESS TITLE	
COUNTY OF DEATH BALTIMORE		CITY OF DEATH BALTIMORE	
STATE OF DEATH MARYLAND		ZIP CODE 21201	

RECEIVED
DEC. 30 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13000
Dr. Wells
 Reg. Dist. No. **302**

1. PLACE OF DEATH a. COUNTY Washington 13032 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 21 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Berkeley c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg d. STREET ADDRESS 909 N. Queen St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First Charles Middle Luther Last Oliver				4. DATE OF DEATH Month Dec. Day 31 Year 1956										
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 13, 1893		9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Experimental Dept.				10b. KIND OF BUSINESS OR INDUSTRY Interwoven Mills		11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.						
13. FATHER'S NAME no record				14. MOTHER'S MAIDEN NAME no record										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Harry A. Spencer, Martinsburg, W. Va.										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="2" style="vertical-align: top;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451x Acute rupture abdominal aortic aneurysm Hemorrhage and shock </td> <td rowspan="3" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> DUE TO (b) arteriosclerotic hypertensive heart disease </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) </td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451x Acute rupture abdominal aortic aneurysm Hemorrhage and shock		INTERVAL BETWEEN ONSET AND DEATH 	DUE TO (b) arteriosclerotic hypertensive heart disease		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451x Acute rupture abdominal aortic aneurysm Hemorrhage and shock		INTERVAL BETWEEN ONSET AND DEATH 												
DUE TO (b) arteriosclerotic hypertensive heart disease														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholelithiasis														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> None				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none										
20c. TIME OF INJURY Month, Day, Year Hour a. m. None p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) —		(County) —		(State) —				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.														
ACTUAL SIGNATURE <i>S. Robert Wells</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 1-2-57						
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										
22b. DATE THEREOF 1-3-1957				22c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery				22d. LOCATION (City, town, or county) Martinsburg, W. Va.						
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md.				24a. REC'D BY REGISTRAR Jan. 4. 1957				24b. REGISTRAR'S SIGNATURE <i>Charles H. Bowers</i>						

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

15N 7 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13033

CERTIFICATE OF DEATH

13001

Reg. Dist. No. 303

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Big Springs RURAL		c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maugansville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Big Spring RFD				d. STREET ADDRESS Mennonite Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Minnie Florence Patton				4. DATE OF DEATH Month Day Year Dec. 8 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1871		9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Ward				14. MOTHER'S MAIDEN NAME Sallie Bowers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Charles Sharron Pinesburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterial Sclerotic 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Heart Dis- DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 19, 1954 to Dec. 8, 1956 , that I last saw the deceased alive on Dec. 8, 1956 , and that death occurred at 2:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE David R. Brewer, M.D.				ADDRESS (Street, city or town, state) Clear Spring Md.			
PHYSICIAN'S NAME (Type) Dr. David R. Brewer							
22a. BURIAL, CREMATION, REMOVAL (specify) Burial		22b. DATE THEREOF Dec. 11, 1956		22c. NAME OF CEMETERY OR CREMATORY Mennonite Cemetery		22d. LOCATION (City, town, or county) (State) Pinesburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf				ADDRESS Williamsport, Md.		24a. REC'D BY REGISTRAR Dec 11/56	
				24b. REGISTRAR'S SIGNATURE Joseph W. Murray			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1910		New York City		Natural		Heart Disease		Jan 15, 1955		New York City		Dr. J. Doe		J. Doe	
Jane Smith		Female		30		Mar 10, 1925		Chicago, Ill.		Accident		Car Crash		Mar 20, 1955		Chicago, Ill.		Dr. A. Smith		A. Smith	
Robert Johnson		Male		60		Oct 5, 1895		Philadelphia, Pa.		Natural		Pneumonia		Nov 1, 1955		Philadelphia, Pa.		Dr. B. Johnson		B. Johnson	
Mary White		Female		25		Jul 1, 1930		Boston, Mass.		Natural		Tuberculosis		Dec 1, 1955		Boston, Mass.		Dr. C. White		C. White	
James Brown		Male		55		Apr 15, 1900		St. Louis, Mo.		Natural		Cancer		Sep 1, 1955		St. Louis, Mo.		Dr. D. Brown		D. Brown	
Elizabeth Green		Female		40		Feb 20, 1915		Cleveland, Ohio		Natural		Stroke		Oct 1, 1955		Cleveland, Ohio		Dr. E. Green		E. Green	
William Black		Male		70		Jun 1, 1885		Pittsburgh, Pa.		Natural		Heart Failure		Aug 1, 1955		Pittsburgh, Pa.		Dr. F. Black		F. Black	
Margaret Hall		Female		35		Nov 10, 1920		San Francisco, Cal.		Natural		Lung Cancer		Jul 1, 1955		San Francisco, Cal.		Dr. G. Hall		G. Hall	
Charles King		Male		65		Mar 5, 1890		New Orleans, La.		Natural		Diabetes		May 1, 1955		New Orleans, La.		Dr. H. King		H. King	
Susan Lee		Female		20		Dec 1, 1935		Los Angeles, Cal.		Natural		Complications of Pregnancy		Sep 1, 1955		Los Angeles, Cal.		Dr. I. Lee		I. Lee	
Thomas Scott		Male		50		Aug 1, 1905		Denver, Colo.		Natural		Kidney Disease		Jun 1, 1955		Denver, Colo.		Dr. J. Scott		J. Scott	
Helen Adams		Female		38		Apr 1, 1917		Portland, Ore.		Natural		Breast Cancer		Oct 1, 1955		Portland, Ore.		Dr. K. Adams		K. Adams	
George Baker		Male		68		Jan 1, 1887		Richmond, Va.		Natural		Prostate Cancer		Jul 1, 1955		Richmond, Va.		Dr. L. Baker		L. Baker	
Frances Miller		Female		28		Sep 1, 1927		San Diego, Cal.		Natural		Epilepsy		May 1, 1955		San Diego, Cal.		Dr. M. Miller		M. Miller	
Edward Wilson		Male		75		Mar 1, 1880		Newark, N.J.		Natural		Alzheimer's Disease		Apr 1, 1955		Newark, N.J.		Dr. N. Wilson		N. Wilson	
Dorothy Moore		Female		32		Nov 1, 1923		Seattle, Wash.		Natural		Leukemia		Sep 1, 1955		Seattle, Wash.		Dr. O. Moore		O. Moore	
Frank Taylor		Male		58		Jun 1, 1897		Columbus, Ohio		Natural		Liver Cancer		Aug 1, 1955		Columbus, Ohio		Dr. P. Taylor		P. Taylor	
Alice Roberts		Female		22		Dec 1, 1933		Phoenix, Ariz.		Natural		Complications of Pregnancy		Oct 1, 1955		Phoenix, Ariz.		Dr. Q. Roberts		Q. Roberts	
Harold Evans		Male		62		Apr 1, 1893		San Antonio, Tex.		Natural		Heart Disease		Jun 1, 1955		San Antonio, Tex.		Dr. R. Evans		R. Evans	
Betty Clark		Female		30		Feb 1, 1925		San Jose, Cal.		Natural		Lung Cancer		Jul 1, 1955		San Jose, Cal.		Dr. S. Clark		S. Clark	
Roy Lewis		Male		72		Jan 1, 1883		New Haven, Conn.		Natural		Stroke		May 1, 1955		New Haven, Conn.		Dr. T. Lewis		T. Lewis	
Norma Harris		Female		25		Oct 1, 1930		San Francisco, Cal.		Natural		Complications of Pregnancy		Sep 1, 1955		San Francisco, Cal.		Dr. U. Harris		U. Harris	
Arthur Young		Male		60		Mar 1, 1895		Portland, Ore.		Natural		Kidney Disease		Aug 1, 1955		Portland, Ore.		Dr. V. Young		V. Young	
Lillian King		Female		35		Nov 1, 1920		San Francisco, Cal.		Natural		Breast Cancer		Oct 1, 1955		San Francisco, Cal.		Dr. W. King		W. King	
Walter Scott		Male		70		Jun 1, 1885		Pittsburgh, Pa.		Natural		Prostate Cancer		Jul 1, 1955		Pittsburgh, Pa.		Dr. X. Scott		X. Scott	
Evelyn Adams		Female		28		Sep 1, 1927		San Diego, Cal.		Natural		Epilepsy		May 1, 1955		San Diego, Cal.		Dr. Y. Adams		Y. Adams	
Gerald Baker		Male		65		Apr 1, 1890		New Orleans, La.		Natural		Diabetes		Jun 1, 1955		New Orleans, La.		Dr. Z. Baker		Z. Baker	
Helen Miller		Female		32		Dec 1, 1923		Seattle, Wash.		Natural		Leukemia		Sep 1, 1955		Seattle, Wash.		Dr. AA. Miller		AA. Miller	
Harold Wilson		Male		75		Mar 1, 1880		Newark, N.J.		Natural		Alzheimer's Disease		Apr 1, 1955		Newark, N.J.		Dr. AB. Wilson		AB. Wilson	
Dorothy Moore		Female		30		Feb 1, 1925		San Jose, Cal.		Natural		Lung Cancer		Jul 1, 1955		San Jose, Cal.		Dr. AC. Moore		AC. Moore	
Frank Taylor		Male		58		Jun 1, 1897		Columbus, Ohio		Natural		Liver Cancer		Aug 1, 1955		Columbus, Ohio		Dr. AD. Taylor		AD. Taylor	
Alice Roberts		Female		22		Dec 1, 1933		Phoenix, Ariz.		Natural		Complications of Pregnancy		Oct 1, 1955		Phoenix, Ariz.		Dr. AE. Roberts		AE. Roberts	
Harold Evans		Male		62		Apr 1, 1893		San Antonio, Tex.		Natural		Heart Disease		Jun 1, 1955		San Antonio, Tex.		Dr. AF. Evans		AF. Evans	
Betty Clark		Female		30		Feb 1, 1925		San Jose, Cal.		Natural		Lung Cancer		Jul 1, 1955		San Jose, Cal.		Dr. AG. Clark		AG. Clark	
Roy Lewis		Male		72		Jan 1, 1883		New Haven, Conn.		Natural		Stroke		May 1, 1955		New Haven, Conn.		Dr. AH. Lewis		AH. Lewis	
Norma Harris		Female		25		Oct 1, 1930		San Francisco, Cal.		Natural		Complications of Pregnancy		Sep 1, 1955		San Francisco, Cal.		Dr. AI. Harris		AI. Harris	
Arthur Young		Male		60		Mar 1, 1895		Portland, Ore.		Natural		Kidney Disease		Aug 1, 1955		Portland, Ore.		Dr. AJ. Young		AJ. Young	
Lillian King		Female		35		Nov 1, 1920		San Francisco, Cal.		Natural		Breast Cancer		Oct 1, 1955		San Francisco, Cal.		Dr. AK. King		AK. King	
Walter Scott		Male		70		Jun 1, 1885		Pittsburgh, Pa.		Natural		Prostate Cancer		Jul 1, 1955		Pittsburgh, Pa.		Dr. AL. Scott		AL. Scott	
Evelyn Adams		Female		28		Sep 1, 1927		San Diego, Cal.		Natural		Epilepsy		May 1, 1955		San Diego, Cal.		Dr. AM. Adams		AM. Adams	
Gerald Baker		Male		65		Apr 1, 1890		New Orleans, La.		Natural		Diabetes		Jun 1, 1955		New Orleans, La.		Dr. AN. Baker		AN. Baker	
Helen Miller		Female		32		Dec 1, 1923		Seattle, Wash.		Natural		Leukemia		Sep 1, 1955		Seattle, Wash.		Dr. AO. Miller		AO. Miller	
Harold Wilson		Male		75		Mar 1, 1880		Newark, N.J.		Natural		Alzheimer's Disease		Apr 1, 1955		Newark, N.J.		Dr. AP. Wilson		AP. Wilson	
Dorothy Moore		Female		30		Feb 1, 1925		San Jose, Cal.		Natural		Lung Cancer		Jul 1, 1955		San Jose, Cal.		Dr. AQ. Moore		AQ. Moore	
Frank Taylor		Male		58		Jun 1, 1897		Columbus, Ohio		Natural		Liver Cancer		Aug 1, 1955		Columbus, Ohio		Dr. AR. Taylor		AR. Taylor	
Alice Roberts		Female		22		Dec 1, 1933		Phoenix, Ariz.		Natural		Complications of Pregnancy		Oct 1, 1955		Phoenix, Ariz.		Dr. AS. Roberts		AS. Roberts	
Harold Evans		Male		62		Apr 1, 1893		San Antonio, Tex.		Natural		Heart Disease		Jun 1, 1955		San Antonio, Tex.		Dr. AT. Evans		AT. Evans	
Betty Clark		Female		30		Feb 1, 1925		San Jose, Cal.		Natural		Lung Cancer		Jul 1, 1955		San Jose, Cal.		Dr. AU. Clark		AU. Clark	
Roy Lewis		Male		72		Jan 1, 1883		New Haven, Conn.		Natural		Stroke		May 1, 1955		New Haven, Conn.		Dr. AV. Lewis		AV. Lewis	
Norma Harris		Female		25		Oct 1, 1930		San Francisco, Cal.		Natural		Complications of Pregnancy		Sep 1, 1955		San Francisco, Cal.		Dr. AW. Harris		AW. Harris	
Arthur Young		Male		60		Mar 1, 1895		Portland, Ore.		Natural		Kidney Disease		Aug 1, 1955		Portland, Ore.		Dr. AX. Young		AX. Young	
Lillian King		Female		35		Nov 1, 1920		San Francisco, Cal.		Natural		Breast Cancer		Oct 1, 1955		San Francisco, Cal.		Dr. AY. King		AY. King	
Walter Scott		Male		70		Jun 1, 1885		Pittsburgh, Pa.		Natural		Prostate Cancer		Jul 1, 1955		Pittsburgh, Pa.		Dr. AZ. Scott		AZ. Scott	
Evelyn Adams		Female		28		Sep 1, 1927		San Diego, Cal.		Natural		Epilepsy		May 1, 1955		San Diego, Cal.		Dr. BA. Adams		BA. Adams	
Gerald Baker		Male		65		Apr 1, 1890		New Orleans, La.		Natural		Diabetes		Jun 1, 1955		New Orleans, La.		Dr. BB. Baker		BB. Baker	
Helen Miller		Female		32		Dec 1, 1923		Seattle, Wash.		Natural		Leukemia		Sep 1, 1955		Seattle, Wash.		Dr. BC. Miller		BC. Miller	
Harold Wilson		Male		75		Mar 1, 1880		Newark, N.J.		Natural		Alzheimer's Disease		Apr 1, 1955		Newark, N.J.		Dr. BD. Wilson		BD. Wilson	
Dorothy Moore		Female		30		Feb 1, 1925		San Jose, Cal.		Natural		Lung Cancer		Jul 1, 1955		San Jose, Cal.		Dr. BE. Moore		BE. Moore	
Frank Taylor		Male		58		Jun 1, 1897		Columbus, Ohio		Natural		Liver Cancer		Aug 1, 1955		Columbus, Ohio		Dr. BF. Taylor		BF. Taylor	
Alice Roberts		Female		22		Dec 1, 1933		Phoenix, Ariz.		Natural		Complications of Pregnancy		Oct 1, 1955		Phoenix, Ariz.		Dr. BG. Roberts		BG. Roberts	
Harold Evans		Male		62		Apr 1, 1893		San Antonio, Tex.		Natural		Heart Disease		Jun 1, 1955		San Antonio, Tex.		Dr. BH. Evans		BH. Evans	
Betty Clark		Female		30		Feb 1, 1925		San Jose, Cal.		Natural		Lung Cancer		Jul 1, 1955		San Jose, Cal.		Dr. BI. Clark		BI. Clark	
Roy Lewis		Male		72		Jan 1, 1883		New Haven, Conn.		Natural		Stroke		May 1, 1955		New Haven, Conn.		Dr. BJ. Lewis		BJ. Lewis	
Norma Harris		Female		25		Oct 1, 1930		San Francisco, Cal.		Natural		Complications of Pregnancy		Sep 1, 1955		San Francisco, Cal.		Dr. BK. Harris		BK. Harris	
Arthur Young		Male		60		Mar 1, 1895		Portland, Ore.		Natural		Kidney Disease		Aug 1, 1955		Portland, Ore.		Dr. BL. Young		BL. Young	
Lillian King		Female		35		Nov 1, 1920		San Francisco, Cal.		Natural		Breast Cancer		Oct 1, 1955		San Francisco, Cal.		Dr. BM. King		BM. King	
Walter Scott		Male		70		Jun 1, 1885		Pittsburgh, Pa.		Natural		Prostate Cancer		Jul 1, 1955		Pittsburgh, Pa.		Dr. BN. Scott		BN. Scott	
Evelyn Adams		Female		28		Sep 1, 1927		San Diego, Cal.		Natural		Epilepsy		May 1, 1955		San Diego, Cal.		Dr. BO. Adams		BO. Adams	
Gerald Baker		Male		65		Apr 1, 1890		New Orleans, La.		Natural		Diabetes		Jun 1, 1955		New Orleans, La.		Dr. BP. Baker		BP. Baker	
Helen Miller		Female		32		Dec 1, 1923		Seattle, Wash.		Natural		Leukemia		Sep 1, 1955		Seattle, Wash.		Dr. BQ. Miller		BQ. Miller	
Harold Wilson		Male		75		Mar 1, 1880		Newark, N.J.		Natural		Alzheimer's Disease		Apr 1, 1955		Newark, N.J.		Dr. BR. Wilson		BR. Wilson	
Dorothy Moore		Female		30		Feb 1, 1925		San Jose, Cal.		Natural		Lung Cancer		Jul 1, 1955		San Jose, Cal.		Dr. BS. Moore		BS. Moore	
Frank Taylor		Male		58		Jun 1, 1897		Columbus, Ohio		Natural		Liver Cancer		Aug 1, 1955		Columbus, Ohio		Dr. BT. Taylor		BT. Taylor	
Alice Roberts		Female		22		Dec 1, 1933		Phoenix, Ariz.		Natural		Complications of Pregnancy		Oct 1, 1955		Phoenix, Ariz.		Dr. BU. Roberts		BU. Roberts	
Harold Evans		Male		62		Apr 1, 1893		San Antonio, Tex.		Natural		Heart Disease		Jun 1, 1955		San Antonio, Tex.		Dr. BV. Evans		BV. Evans	
Betty Clark		Female		30		Feb 1, 1925		San Jose, Cal.		Natural		Lung Cancer		Jul 1, 1955		San Jose, Cal.		Dr. BW. Clark		BW. Clark	
Roy Lewis		Male		72		Jan 1, 1883		New Haven, Conn.		Natural		Stroke		May 1, 1955		New Haven, Conn.		Dr. BX. Lewis		BX. Lewis	
Norma Harris		Female		25		Oct 1, 1930		San Francisco, Cal.		Natural		Complications of Pregnancy		Sep 1, 1955		San Francisco, Cal.		Dr. BY. Harris		BY. Harris	
Arthur Young		Male		60		Mar 1, 1895		Portland, Ore.		Natural		Kidney Disease		Aug 1, 1955		Portland, Ore.		Dr. BZ. Young		BZ. Young	
Lillian King		Female		35		Nov 1, 1920		San Francisco, Cal.		Natural		Breast Cancer		Oct 1, 1955		San Francisco, Cal.		Dr. CA. King		CA. King	
Walter Scott		Male		70		Jun 1, 1885		Pittsburgh, Pa.		Natural		Prostate Cancer		Jul 1, 1955		Pittsburgh, Pa.		Dr. CB. Scott		CB. Scott	

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13034

13002

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Waynesboro</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				d. STREET ADDRESS <u>131 E Main St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Barbara Ella Peters</u>				4. DATE OF DEATH Month Day Year <u>12 15 1956</u>			
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 15, 1876</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>WAYNESBORO, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEWIS HARDMAN</u>				14. MOTHER'S MAIDEN NAME <u>LUCINDA HARMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <u>Mrs. Minerva Baker</u> Address <u>3210 W. 2nd St. Williamsport, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>260x</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Diabetes mellitus</u> (c) <u>4 years</u> <u>57 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>11 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1955</u> to <u>15 Dec 1956</u> , that I last saw the deceased alive on <u>15 Dec 1956</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>280 W. Antoneac Street Williamsport, Pa.</u> DATE SIGNED <u>15 Dec 56</u>							
ACTUAL SIGNATURE <u>Paul Hank</u> PHYSICIAN'S NAME (Type) <u>PAUL HANK, M.D.</u>				M.D. <u>Williamsport, Pa.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro Franklin Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Grove</u> ADDRESS <u>Waynesboro Pa.</u>				24a. REC'D BY REGISTRAR <u>DEC 17 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Emmette McElroy</u>	

CERTIFICATE OF DEATH

1955

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. EDUCATION</p> <p>9. RELIGION</p> <p>10. RACE</p> <p>11. COLOR</p> <p>12. ETHNIC ORIGIN</p> <p>13. PLACE OF DEATH</p> <p>14. DATE OF DEATH</p> <p>15. TIME OF DEATH</p> <p>16. CAUSE OF DEATH</p> <p>17. MANNER OF DEATH</p> <p>18. SIGNATURE OF PHYSICIAN</p> <p>19. SIGNATURE OF REGISTRAR</p> <p>20. SIGNATURE OF WITNESSES</p>	
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BUREAU V. 3

DEC 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13035

CERTIFICATE OF DEATH

13003

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown		c. LENGTH OF STAY IN 1b 22 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Convalescent Home		d. STREET ADDRESS RFD #2	
3. NAME OF DECEASED (Type or print) Maude Oswald Pound		4. DATE OF DEATH Dec. 17, 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1882
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Cavetown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George A. Pound		14. MOTHER'S MAIDEN NAME Sarah Oswald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. - -	
17. INFORMANT George Pound, Smithsburg, RD 2, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Intestines 152X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 mo. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 15, 1956 , to Dec. 17, 1956 , that I last saw the deceased alive on Dec. 17, 1956 , and that death occurred at 11:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE David R. Brewer M.D.		ADDRESS (Street, city or town, state) Clear Spring Md.	
DATE SIGNED 12/18/56			
PHYSICIAN'S NAME (Type) David R. Brewer			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12-20-56	
22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR DEC 21 1956	
24b. REGISTRAR'S SIGNATURE Chas. J. Brewer			

CERTIFICATE OF DEATH

DEATH OF GEORGE A. POUND DATE OF DEATH DEC 17 1956 PLACE OF DEATH HOME		AGE 68 YEARS SEX MALE RACE WHITE	
OCCUPATION HOUSE WORK CAUSE OF DEATH HEART DISEASE MANNER OF DEATH NATURAL		PLACE OF BIRTH NEW YORK DATE OF BIRTH APR 10 1888 PLACE OF BIRTH NEW YORK	
SIGNATURE OF DECEASED GEORGE A. POUND SIGNATURE OF WITNESS GEORGE A. POUND SIGNATURE OF PHYSICIAN GEORGE A. POUND		SIGNATURE OF REGISTRAR GEORGE A. POUND SIGNATURE OF CLERK GEORGE A. POUND SIGNATURE OF JURY GEORGE A. POUND	

BUREAU V. 1

DEC 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12986 Dr Lewis Graff
CERTIFICATE OF DEATH

13004

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>603 No Prospect St</u>		d. STREET ADDRESS <u>603 No Prospect St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE GERTRUDE POWERS</u>		4. DATE OF DEATH Month Day Year <u>December 25 1956 19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24 1889</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>William sport</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis McElroy</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wolford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>William H. Powers</u>		Address <u>603 N. Prospect St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>247.1</u> (b) <u>Gen. Arteriosclerosis and cardiovascular disease.</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes.</u> <u>Yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus -</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>56</u> , to <u>Dec. 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 23</u> , 19 <u>56</u> , and that death occurred at <u>2</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis G. Graff</u>		ADDRESS (Street, city or town, state) <u>119 E. Antietam St. Hagerstown Md.</u>	
PHYSICIAN'S NAME (Type) <u>Louis G. Graff, M.D.</u>		DATE SIGNED <u>12-26-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-27-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Church of Breth Cem.</u>	22d. LOCATION (City, town, or county) <u>Brownsville, Md. Wash. Co</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>Dec 28, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Wm H. Powers</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES J. JONES		M		35		JAN 15 1921		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JAN 15 1945		NEW YORK		NEW YORK		NEW YORK		UNITED STATES		JAN 15 1956		NEW YORK	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		CITY OF OCCUPATION		STATE OF OCCUPATION		COUNTRY OF OCCUPATION		DATE OF DEATH		PLACE OF DEATH	
FARMER		JAN 15 1945		NEW YORK		NEW YORK		NEW YORK		UNITED STATES		JAN 15 1956		NEW YORK	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH		CITY OF CAUSE OF DEATH		STATE OF CAUSE OF DEATH		COUNTRY OF CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		JAN 15 1956		NEW YORK		NEW YORK		NEW YORK		UNITED STATES		JAN 15 1956		NEW YORK	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		CITY OF MANNER OF DEATH		STATE OF MANNER OF DEATH		COUNTRY OF MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
NATURAL		JAN 15 1956		NEW YORK		NEW YORK		NEW YORK		UNITED STATES		JAN 15 1956		NEW YORK	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		JAN 15 1956		NEW YORK		NEW YORK		NEW YORK		UNITED STATES		JAN 15 1956		NEW YORK	
SIGNATURE OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		JAN 15 1956		NEW YORK		NEW YORK		NEW YORK		UNITED STATES		JAN 15 1956		NEW YORK	

RECEIVED
DEC 31 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13005

13035

CERTIFICATE OF DEATH

Reg. Dist. No.

201

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport c. LENGTH OF STAY IN 1b Lifetime d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 115 S. Artizan St.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport d. STREET ADDRESS 115 S. Artizan St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First Middle Last Linda Kay Reed		4. DATE OF DEATH Month Day Year Dec. 15 1956		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 11, 1953		9. AGE (In years lost birthday) yrs. Months Days Min. 3 yrs. 8 mos. 3 days		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Wash. Co. Hospital		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Eugene Reed				14. MOTHER'S MAIDEN NAME Betty Lorraine Rowe				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT David Reed 115 S. Artizan Street Williamsport, Md.							
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chickpox & Convulsions DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1/2 Day														PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Hour o. p. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from 12/15/56 19 56 , to 12/15/56 , that I last saw the deceased alive on 12/15/56 , and that death occurred at 3 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Williamsport, Md. DATE SIGNED 12/15/56																					
ACTUAL SIGNATURE Reph L. Young				M.D. Williamsport, Md.				ADDRESS (Street, city or town, state) Williamsport, Md.				DATE SIGNED 12/15/56									
PHYSICIAN'S NAME (Type) Reph L. Young																					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec. 17, 1956				22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery				22d. LOCATION (City, town, or county) (State) Williamsport, Maryland.									
23. FUNERAL DIRECTOR'S SIGNATURE Albert A. Leaf				ADDRESS Williamsport, Md.				24a. REC'D BY REGISTRAR Dec. 15-56				24b. REGISTRAR'S SIGNATURE E. Lee M. Elroy									

DEC 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12987

CERTIFICATE OF DEATH

Reg. Dist. No.

13096

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 13 Mapel Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lillian Mary Reynolds				4. DATE OF DEATH Month Day Year Dec. 1 19 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1882		9. AGE (In years last birthday) 74 7 1/2	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME M. W. Allison				14. MOTHER'S MAIDEN NAME Favoretta C. Stockslager			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) --		17. INFORMANT Address Franklin Reynolds, Smithsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 6 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/19/56 , 19 56 , to 12/1 , 19 56 , that I last saw the deceased alive on 12/1 , 19 56 , and that death occurred at 4:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED							
ACTUAL SIGNATURE Charles F. Hess M.D.				DATE SIGNED 12-7-56			
PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.				24b. REGISTRAR'S SIGNATURE Chas. H. Bowers			
22b. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12-4-1956		22c. NAME OF CEMETERY OR CREMATORY Smithsburg, Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.				24a. REC'D BY REGISTRAR 12-7-56			

CERTIFICATE OF DEATH

MINNESOTA STATE DEPARTMENT OF HEALTH - BULLETIN 12 -

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan. 1, 1910		St. Paul, Minn.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Physician		High School		Catholic	
Date of Death		Time of Death		Place of Death		Physician		Burial Place	
Dec. 1, 1956		10:00 AM		St. Paul, Minn.		Dr. J. Smith		St. Paul, Minn.	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Funeral Director	
J. Smith		A. Doe		B. Doe		C. Doe		D. Doe	

BUREAU V. 1

DEC 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13007

13037

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>			
c. LENGTH OF STAY IN 1b <u>15 yrs</u>				d. STREET ADDRESS <u>Hagerstown Route #6</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hagerstown Route #6</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>E.</u> Last <u>Risser</u>		4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>1956</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/10/1862</u>	9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Lancaster Co. Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Risser</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Eby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Allen A. Risser, Hagerstown Route #6, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>General Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility</u> DUE TO (c) <u>Senility</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>16 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-1-1956</u> to <u>12-30-1956</u> , that I last saw the deceased alive on <u>12-29-1956</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. E. W. Smith</u>				ADDRESS (Street, city or town, state) <u>Hagerstown Md</u>			
PHYSICIAN'S NAME (Type) <u>A. E. W. Smith</u>				DATE SIGNED <u>12/31/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/2/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reiffs Memorial Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald M. Zimmerman</u>				ADDRESS <u>Greencastle, Pa</u>		24a. REC'D BY REGISTRAR <u>Jan 2 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Charles H. Howard</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13008

12988

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Williamsport,		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS Williamsport, R.F.D. #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Russell Rowe				4. DATE OF DEATH Month Day Year December 10 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 9, 1906	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Attnd. Service Sta.				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Charles H. Rowe				14. MOTHER'S MAIDEN NAME Bessie Gossard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 216-07-1229		17. INFORMANT Mrs. Hazel Rowe		Address R.F.D. #2 Williamsport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiogenic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 162X DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 months							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5 Dec , 19 56 , to 10 Dec , 19 56 , that I last saw the deceased alive on 10 Dec , 19 56 , and that death occurred at 3:20 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul Hawk				ADDRESS (Street, city or town, state) 28 W. Patomac Street Williamsport, Md.		DATE SIGNED 11 Dec 56	
PHYSICIAN'S NAME (Type) PAUL HAWK, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 13, 1956		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf				ADDRESS Williamsport, Md.		24a. REC'D BY REGISTRAR Dec. 13, 1956	
				24b. REGISTRAR'S SIGNATURE W. H. Bowers			

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		DATE OF BIRTH [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	
SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF DECEASED [Illegible]	

BUREAU V. 3

DEC 17 1956

RECEIVED

12989

CERTIFICATE OF DEATH

Reg. Dis. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLARENCE Middle ALBERTUS Last ROWLAND				4. DATE OF DEATH Month December Day 8 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 1, 1889	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 1 Days 7		IF UNDER 24 HRS. Hours 7 Min. 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Maker				10b. KIND OF BUSINESS OR INDUSTRY Organ Factory		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Albertus David Rowland				14. MOTHER'S MAIDEN NAME Hattie May Lum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-09-2460A		17. INFORMANT Address Irene Kailer Rowland Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis Bilateral 002X DUE TO Far advanced active Hemorrhage Nov 28-56 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Far advanced active Hemorrhage DUE TO (c) Far advanced active Hemorrhage							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 12 , 19 56 , to Nov 8 , 19 56 , that I last saw the deceased alive on Nov 8 , 19 56 , and that death occurred at 4:25 A.M. , from the causes and on the date stated above.							DATE SIGNED
ACTUAL SIGNATURE Sidney Novenstein M.D.				ADDRESS (Street, city or town, state) Funkstown Md			
PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/1956		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Houzer Funeral Home R. Franklin Ruzer				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Dec 10 1956	
				24b. REGISTRAR'S SIGNATURE Blair H. Toward			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1956

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and medical history. The form is partially filled out with handwritten text.

BUREAU V. S.

DEC 13 1956

RECEIVED

13038

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>10 mon. 22d</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				d. STREET ADDRESS <u>125 N. Locust</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Isaac Newton Runberger</u>				4. DATE OF DEATH Month Day Year <u>December 2 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 5, 1863</u>	9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baggageman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R. R. Express</u>		11. BIRTHPLACE (State or foreign country) <u>Funkstown Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Phares Runberger</u>				14. MOTHER'S MAIDEN NAME <u>Mary Monroe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Sanitarium Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Vascular Disease</u> DUE TO (c) <u>Arteriosclerosis - Generalized</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>2 yrs.</u> <u>5 yrs. +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1951</u> to <u>Dec 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 2</u> , 19 <u>56</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Lloyd A. Hoffman</u> M.D. <u>214 N. Potomac St. Hagerstown, Md.</u> DATE SIGNED <u>12/3/56</u> PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-5-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Dec 8-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>E. Lee McElroy</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 51

DEC 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13011
Reg. Dist. No. 308

13039

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hagerstown</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Boonsboro</u>			c. LENGTH OF STAY IN 1b <u>2 years 8 mo.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Boonsboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Boonsboro R.F.D. # 1</u>				d. STREET ADDRESS <u>R.F.D. # 1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES MILTON SHAULL</u>				4. DATE OF DEATH Month Day Year <u>December 16 1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 14, 1900</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>			11. BIRTHPLACE (State or foreign country) <u>Jefferson County, W. Vir.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Shaull</u>				14. MOTHER'S MAIDEN NAME <u>Ida Mae Watson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>236-14-3977</u>		17. INFORMANT <u>Charles F. Shaull</u> Address <u>Boonsboro Rt. 1, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot thru mouth into crenium</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO cause lost, (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) <u>Shot self thru mouth with .22 calibre gun</u>					
20c. TIME OF INJURY Month, Day, Year <u>5:00 p. m. Dec. 16 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at home</u>		20f. (City or town) (County) (State) <u>Rural- Boonsboro, Md Wash Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u> EXAMINER'S NAME (Type) <u>S, Robert Wells, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>12-17-56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/19/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Dale Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Martinsburg, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Rouzer</u> ADDRESS <u>Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>Dec. 19, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John A. Baird</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

DEC 26 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12990

CERTIFICATE OF DEATH

Reg. Dist. No.

13012
302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>17 Fenton Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>William Henry Albert Sheeler</u>		4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 20, 1884</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Foundry</u>	11. BIRTHPLACE (State or foreign country) <u>Waynesboro Pa.</u>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Thomas Sheeler</u>		14. MOTHER'S MAIDEN NAME <u>Mary K Albert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-18-8730</u>	17. INFORMANT <u>Mrs. Edna Rickett</u> Address <u>Williamsport Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/6/56</u> , 19 <u>56</u> to <u>12/7/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/7/56</u> , 19 <u>56</u> , and that death occurred at <u>12:30 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Williamsport, Md</u> DATE SIGNED <u>12/10/56</u> ACTUAL SIGNATURE <u>Ralph F. Young</u> M.D. PHYSICIAN'S NAME (Type) <u>William Sheeler</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-10-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u>		ADDRESS <u>Hagerstown Md.</u>	24a. REC'D BY REGISTRAR <u>Dec. 10, 1956</u>
		24b. REGISTRAR'S SIGNATURE <u>Blair H. Bowers</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 130182

12991

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) ✓ a. STATE <u>Pa.</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>17hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsburgh 12</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co. Hospital</u>				d. STREET ADDRESS <u>123 W. Ohio St. Nor. Side</u>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Marie</u> Last <u>Shermer</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Nov. 15 1908</u>		9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Greensburg, Pa.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>				13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>201-14-7790</u>				17. INFORMANT Address <u>Donald Shermer Fort Ritchie, Cascade, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia due to over dosage of barbiturates</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Over dosage of sleeping capsules</u>							
20c. TIME OF INJURY Month, Day, Year <u>6:30 a.m. Dec. 15 1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hotel Room - Dager Hagerstown Wash Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>S. Robert Wells, M. D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u>				ADDRESS <u>Hagerstown, Md.</u>			
24a. REC'D BY REGISTRAR <u>Dec. 21, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H. H.</u>					

MEDICAL CERTIFICATION

23

1

2

2

44

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DATE SIGNED
Dec. 16 1956

RECEIVED

DEC 26 1956

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____
2. SEX: _____
3. AGE: _____
4. DATE OF BIRTH: _____
5. PLACE OF BIRTH: _____
6. OCCUPATION: _____
7. CAUSE OF DEATH: _____
8. MANNER OF DEATH: _____
9. SIGNATURE OF EXAMINER: _____
10. DATE OF EXAMINATION: _____

11. SIGNATURE OF ATTENDING PHYSICIAN: _____
12. DATE OF DEATH: _____

13. SIGNATURE OF CORONER: _____
14. DATE OF DEATH: _____

15. SIGNATURE OF JURY: _____
16. DATE OF DEATH: _____

17. SIGNATURE OF JURY: _____
18. DATE OF DEATH: _____

19. SIGNATURE OF JURY: _____
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21. SIGNATURE OF JURY: _____
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98. DATE OF DEATH: _____

99. SIGNATURE OF JURY: _____
100. DATE OF DEATH: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13014

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W.Va. b. COUNTY Berkeley	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitarium		d. STREET ADDRESS R.F.D. # 2	
3. NAME OF DECEASED (Type or print) Ethel Bernice Shockey		4. DATE OF DEATH Month Dec. Day 20 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13, 1876
9. AGE (In years last birthday) 80 yrs		IF UNDER 1 YEAR Months 4 Days 7 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House duties		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Frederick Co., Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesse Finch		14. MOTHER'S MAIDEN NAME Edmonia Finch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Milton Porterfield		Address W.Va. Martinsburg	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 6 hours 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 Dec , 19 56 , to 19 Dec , 19 56 , that I last saw the deceased alive on 19 Dec , 19 56 , and that death occurred at 12:55 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul Haak M.D.		ADDRESS (Street, city or town, state) 58 W. Patomac Street DATE SIGNED 21 Dec 56	
PHYSICIAN'S NAME (Type) PAUL HAAK, M.D.		Williamsport, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/22/56	
22c. NAME OF CEMETERY OR CREMATORY Greenway		22d. LOCATION (City, town, or county) (State) Berkeley Springs W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. Brown		ADDRESS Martinsburg W.Va.	
24a. REC'D BY REGISTRAR DEC 20 1956		24b. REGISTRAR'S SIGNATURE Emmanuel McElroy	

CERTIFICATE OF DEATH

Date of Death Dec. 20 1956		Place of Death Baltimore	
Name of Deceased Mrs. Milton Portenfeld		Name of Informant Mrs. Milton Portenfeld	
Sex Female		Race White	
Age 73		Date of Birth Aug. 13, 1876	
Usual Residence 1000 W. 10th St. Baltimore 11		Present Residence 1000 W. 10th St. Baltimore 11	
Cause of Death Senile Dementia		Date of Death Dec. 20 1956	
Physician Dr. J. H. ...		Coroner ...	
Burial Place ...		Date of Burial ...	
Signature of Physician ...		Signature of Coroner ...	

BUREAU V. 2

DEC 26 1956

RECEIVED

Maryland State Department of Health

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13015	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 004	
1. PLACE OF DEATH a. COUNTY 13041 Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hancock					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hancock Jail					d. STREET ADDRESS R # 2			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Albert Shoemaker					4. DATE OF DEATH Dec. 20		Day 19 Year 56				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 13, 1901		9. AGE (In years last birthday) 55 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY B & O		11. BIRTHPLACE (State or foreign country) Washington County		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Tobias J. Shoemaker					14. MOTHER'S MAIDEN NAME Mary C. Fink						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yrs. no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-9252		17. INFORMANT Mrs. Lula Eichelberger Hancock, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 903.5 IMMEDIATE CAUSE (a) Fractured Skull - hemorrhage and shock DUE TO Chronic Alcoholism Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. 352.1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Undetermined yet Fell striking head against sidewalk - accident							
20c. TIME OF INJURY Month, Day, Year Hour o. m. Dec. 19 19 56 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Undetermined yet		20f. (City or town) (County) (State) Hancock Wash Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE S. Robert Wells					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			12-26-56			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-24-56		22c. NAME OF CEMETERY OR CREMATORY Stone Bridge			22d. LOCATION (City, town, or county) (State) Hancock Wash Md				
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Stone					ADDRESS Hancock Md		24a. REC'D BY REGISTRAR 12/27/56		24b. REGISTRAR'S SIGNATURE J. H. Keller		

BUREAU V. S.

JAN 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12992

CERTIFICATE OF DEATH

Reg. Dist. No.

13016
302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 14 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Eugene Shumaker		First Middle Last		4. DATE OF DEATH Dec 6 1956		Month Day Year 12 7 19 56	
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 6 1956	
9. AGE (In years last birthday) 14 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) md	
12. CITIZEN OF WHAT COUNTRY? u s a		13. FATHER'S NAME Earl Shumaker		14. MOTHER'S MAIDEN NAME Catherine Battrell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Earl Shumaker Address Sharpsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atedegnis 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intrauterine Fetus DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 14 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Sharpsburg				20g. (County) Md.		20h. (State) Md.	
21. I certify that I attended the deceased from 12/6 , 19 56 , to 12/7 , 19 56 , that I last saw the deceased alive on 12/6 , 19 56 , and that death occurred at 12/7 , 19 56 , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter H. Sheedy				M.D. Sharpsburg, Md.		DATE SIGNED 12/7/56	
PHYSICIAN'S NAME (Type) Walter H. Sheedy							
22a. BURIAL, CREMATION, REMOVAL (Specify) Dec 8 1956		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Mountain View		22d. LOCATION (City, town, or county) (State) Sharpsburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf-Williams				ADDRESS 2081271XV7		24a. REC'D BY REGISTRAR Dec 11 1956	
24b. REGISTRAR'S SIGNATURE Walter H. Sheedy							

CERTIFICATE OF DEATH

Name of Deceased MAHER, JOHN		Age 14 yrs	
Sex Male		Race White	
Date of Death Dec 11 1956		Place of Death Home	
Cause of Death Heart Disease		Manner of Death Natural	
Signature of Physician [Signature]		Signature of Registrar [Signature]	
Date of Report Dec 13 1956		Place of Report Home	

BUREAU V. 8

DEC 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr Wells

Reg. Dist. No. 302

12993

13017

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>9 Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>835 Rose Hill Ave</u>				d. STREET ADDRESS <u>835 Rose Hill Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE ELIZABETH SNYDER</u>				4. DATE OF DEATH Month Day Year <u>December 7 1956 19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23 1909</u>		9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Howard Stickler</u>				14. MOTHER'S MAIDEN NAME <u>Susie Crunkleton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Simon E. Snyder Jr 835 Rose Hill Ave Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide poisoning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mentally Ill</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found in automobile in garage with ignition on and car out of gas</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>10 30 AM Dec. 7 19 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Garage</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>Dec. 11, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>L. H. H. Bowers</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

DEC 18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13042

CERTIFICATE OF DEATH

Reg. Dist. No.

13018

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonesboro		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrotts Mills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Nursing Home		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nancy Middle Belle Last Spencer		4. DATE OF DEATH Month 12 Day 11 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-1876
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Franklin Shotts		14. MOTHER'S MAIDEN NAME Permelia Pingley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Rev. Morris Spencer, Frederick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia - DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 yrs. 7 days		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 10 , 19 56 , to Dec. 11 , 19 56 , that I last saw the deceased alive on Dec. 10 , 19 56 , and that death occurred at 7:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. W. Lavan		ADDRESS (Street, city or town, state) Boonesboro	
PHYSICIAN'S NAME (Type) G. W. Lavan		DATE SIGNED 12/15/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-16-56	22c. NAME OF CEMETERY OR CREMATORY Reformed	22d. LOCATION (City, town, or county) (State) Knoxville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE B. K. Felt		ADDRESS Brunswick, Maryland	
24a. REC'D BY REGISTRAR DATE 19 1956		24b. REGISTRAR'S SIGNATURE John A. Best	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in appearance within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13019

12994

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 225 S. LOCUST ST.	
3. NAME OF DECEASED (Type or print) DAISY ELLEN STOTTLEMYER		4. DATE OF DEATH DECEMBER 8 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/24/1873
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY STEM		14. MOTHER'S MAIDEN NAME FANNIE WAGAMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. FRANCES WERKING		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days. 3-4 years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6 , 19 53 , to Dec. 8 , 19 56 , that I last saw the deceased alive on Dec. 8 , 19 56 , and that death occurred at 9:55 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE George Jennings		DATE SIGNED 12/10/56	
PHYSICIAN'S NAME (Type) George Jennings		Address 136 W. Washington St. Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/11/56	
22c. NAME OF CEMETERY OR CREMATORY CH. OF GOD CEM.		22d. LOCATION (City, town, or county) (State) BETHEL WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Dec. 12, 1956		24b. REGISTRAR'S SIGNATURE Chas. H. Bowers	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13020

12995

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 40 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 349 Ridge Ave.				d. STREET ADDRESS 349 Ridge Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle G Last STRASBAUGH				4. DATE OF DEATH Month Dec. Day 26 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 18, 1889		9. AGE (In years lost birthday) yrs. 67 Months 4 Days 1 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Moulder			10b. KIND OF BUSINESS OR INDUSTRY Foundry		11. BIRTHPLACE (State or foreign country) Hanover, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John Strasbaugh				14. MOTHER'S MAIDEN NAME Anna Mary Jacobs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-2472		17. INFORMANT Mrs. Robert Davis Address 349 Ridge Ave. Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 1. Month July Day 19 Year 1956 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 19 56 , to 26 Dec , 19 56 , that I last saw the deceased alive on 7 Dec , 19 56 , and that death occurred at 5:25 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. D. Wilson				ADDRESS (Street, city or town, state) 135 N Potomac St. Hagerstown Md.			
PHYSICIAN'S NAME (Type) J. D. Wilson, M. D.				DATE SIGNED 12/26			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 29, 1956		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.				24a. REC'D BY REGISTRAR Dec. 28, 1956		24b. REGISTRAR'S SIGNATURE Phyllis Bowers	

Wm. A. Horak U-Pro

CERTIFICATE OF DEATH

Name of Deceased Mary Ann Maiden Name Mary Ann		Date of Birth 11 yrs.	
Place of Birth Baltimore, Md.		Date of Death Nov. 20, 1950	
Usual Residence 605 Maryland Ave.		Cause of Death Coronary Thrombosis	
Name of Physician Frederick J. Jones, M.D.		Name of Hospital St. Joseph's Hospital	
Name of Undertaker Frederick J. Jones, M.D.		Name of Burial Place St. Joseph's Cemetery	
Name of Registrar Margaret A. Bauman		Date of Registration Nov. 20, 1950	
Name of County Baltimore		Name of State Maryland	

BURIED 11.3

NOV 21 1950

RECEIVED

ROBERT V. WILSON & SON, BALTIMORE, MD.
 11-25
 ROSE GILL, BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12997

CERTIFICATE OF DEATH

13022

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>A. P.</u> Last <u>THOMPSON</u>				4. DATE OF DEATH Month <u>December</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 9, 1900</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Huntington, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Serena Snowden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W. W. II</u>				16. SOCIAL SECURITY NO. <u>162-12-9318</u>		17. INFORMANT <u>John E. Thompson</u> Address <u>Mt. Union Pennsylvania</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C-V Disease</u> DUE TO (c) <u>Unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 hours</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>Dec. 16, 1956</u> , to <u>Dec. 18, 1956</u> that I lost saw the deceased olive on <u>Dec. 18, 1956</u> , and that death occurred at <u>2:30</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u></u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>L. L. Parker</u> M.D. <u></u>							
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/21/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Huntington, Pa.</u>				(State) <u></u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Franklin Proyer</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Dec. 21, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Chas. H. Powers</u>							

DEC 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Keadle

13023

12998

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>MARY</u> Last <u>TRACY</u>			4. DATE OF DEATH Month <u>December</u> Day <u>23</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5 1890</u>		9. AGE (In years last birthday) <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Rockdale Wash. Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Samuel Hose</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Suman</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>George W. Tracy 810 Georgia Ave</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>① Acute Pulmonary edema</u> DUE TO <u>416X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>② Rheumatic heart disease</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>indefinite</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hepatomegaly due to ② above. Cholelithiasis</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>1952</u> , 19 <u>52</u> , to <u>12-23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-23</u> , 19 <u>56</u> , and that death occurred at <u>1030 P.</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Robert F. Keadle</u> M.D.		ADDRESS (Street, city or town, state) <u>Hagerstown Md</u> DATE SIGNED <u>12-26-56</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT F. KEADLE</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/26/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dunkard Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Broadfording Wash. Co Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>			ADDRESS <u>Hagerstown Md.</u>		
24a. REC'D BY REGISTRAR <u>27.1956</u>			24b. REGISTRAR'S SIGNATURE <u>phsthr30 wew</u>		

RECEIVED

DEC 31 1956

BUREAU V. A.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

REG. NO. 1000

CERTIFICATE OF DEATH

13024

Reg. Dist. No. 302

12999

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.				c. LENGTH OF STAY IN 1b 30yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 647 Pennsylvania Ave.				d. STREET ADDRESS 647 Pennsylvania Ave.			
3. NAME OF DECEASED (Type or print) First Annie Middle Mary Last Wallace				4. DATE OF DEATH Month Dec Day 18 Year 1956			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 4 1885	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Washington Va.	
12. CITIZEN OF WHAT COUNTRY? USA.							
13. FATHER'S NAME Coliven Jackson				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs Vuller Smith 647 Pennsylvania Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinome breast 170X DUE TO Metastasis to lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month. Day, Year Hour a. m. None 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Oct. 19 48 , to Dec. 18 , 19 56 , that I last saw the deceased alive on Dec. 18 , 19 56 , and that death occurred at 9:35 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 N. Potomac Street DATE SIGNED _____ ACTUAL SIGNATURE S. Robert Wells M.D. 115 N. Potomac Street PHYSICIAN'S NAME (Type) S. Robert Wells, M.D. Hagerstown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-20-1956		22c. NAME OF CEMETERY OR CREMATORY Rose Mill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr. Hagerstown Md.				24a. REC'D BY REGISTRAR Dec. 22, 1956		24b. REGISTRAR'S SIGNATURE W. H. Powers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE 18

EC 26 1056

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13000

CERTIFICATE OF DEATH

13025

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. STREET ADDRESS 25 1/2 W. Franklin Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) IRA First WALTER LEE Middle WHITTINGTON Last				4. DATE OF DEATH Month December Day 27 Year 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 12, 1899	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 2 Days 15		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paint contractor				10b. KIND OF BUSINESS OR INDUSTRY own business		11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Whittington				14. MOTHER'S MAIDEN NAME Hattie Wilkerson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes <input checked="" type="checkbox"/> W.W. I		16. SOCIAL SECURITY NO. 217-10-3268		17. INFORMANT Mrs. Lilian B. Whittington Address Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis (c) Coronary arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential hypertension							
INTERVAL BETWEEN ONSET AND DEATH 10 hrs				INTERVAL BETWEEN ONSET AND DEATH 10 hrs			
INTERVAL BETWEEN ONSET AND DEATH indefinite				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 5 , 19 56 , to Dec 27 , 19 56 , that I last saw the deceased alive on Dec. 27 , 19 56 , and that death occurred at 2:45 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul Harrison				ADDRESS (Street, city or town, state) 378 N. Potomac ST			
PHYSICIAN'S NAME (Type) PAUL HARRISON MD				DATE SIGNED 12-28-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/30/1956		22c. NAME OF CEMETERY OR CREMATORY Broadfording Cemetery		22d. LOCATION (City, town, or county) Broadfording, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Rizer				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Dec. 29, 1956	
				24b. REGISTRAR'S SIGNATURE Phyllis Powers			

CERTIFICATE OF DEATH

11

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		65		JAN 15 1880		BALTIMORE		MD		USA			
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY	
RETIRED		HEART DISEASE		NATURAL		2 WEEKS		JAN 20 1957		10:00 AM		BALTIMORE		MD	
FATHER'S NAME		MOTHER'S NAME		SPOUSE'S NAME		CHILDREN		EDUCATION		RELIGION		RACE		COLOR	
JAMES H. HARRIS		MARY J. HARRIS		JOHN A. HARRIS		3		HIGH SCHOOL		METHODIST		WHITE		WHITE	
PREVIOUS ILLNESS		HISTORY OF PRESENT ILLNESS		TREATMENT		POST-MORTEM		BURIAL		FUNERAL		CITY		STATE	
NONE		HEART DISEASE		NONE		NONE		BALTIMORE		BALTIMORE		MD		USA	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION		TIME OF REGISTRATION		PLACE OF REGISTRATION		CITY	
								JAN 20 1957		10:00 AM		BALTIMORE		MD	

BUREAU V. S.

JAN 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13026
(13026)

13001

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Jacob Wiederhold		4. DATE OF DEATH Month December Day 10 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 28, 1891
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Engineer	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph C. Wiederhold		14. MOTHER'S MAIDEN NAME Louisa Himes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-0383	
17. INFORMANT Mrs Mary Wiederhold		Address 1103 Penna. Ave. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Coronary Arteriosclerosis DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 4 hours 4 years 1 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/6/54 , 19____, to 12/10/56 , 19____, that I last saw the deceased alive on 12/10/56 , 19____, and that death occurred at 9:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12/12/56			
ACTUAL SIGNATURE <i>S. Earl Young</i>		M.D. 12/12/56	
PHYSICIAN'S NAME (Type) S. Earl Young, M. D., 148 N. Potomac St., Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 13, 1956	
22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Albert A. Leaf</i>		24a. REC'D BY REGISTRAR Dec. 14, 1956	
ADDRESS Williamsport, Md.		24b. REGISTRAR'S SIGNATURE <i>Charles Bowers</i>	

CERTIFICATE OF DEATH

NAME		JAMES W. WILSON	
AGE		65 years	
SEX		Male	
RACE		White	
BIRTH DATE		1903	
BIRTH PLACE		Maryland	
DEATH DATE		1956	
DEATH PLACE		Baltimore, Maryland	
CAUSE OF DEATH		Chronic Coronary Arteriosclerosis	
MANNER OF DEATH		Natural	
SIGNATURE		[Signature]	
DATE		1956	

BUREAU V. 3

DEC 17 1956

RECEIVED

13002

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keedysville RFD #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Edith</u> Last <u>Witmer</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>19</u> Year <u>19 56</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16 1919</u>		9. AGE (In years last birthday) <u>37</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>dress factory</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Holly Holingsworth Turner</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Iona Bowers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>214-160981</u>		17. INFORMANT <u>Harry William Witmer Keedysville, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>590x</u> DUE TO <u>acute nephritis with retention of urine</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 12</u> , 19 <u>56</u> , to <u>Dec 19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 18</u> , 19 <u>56</u> , and that death occurred at <u>9:30 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William</u> M.D.				ADDRESS (Street, city or town, state) <u>Bowling Green</u> DATE SIGNED <u>12/19/56</u>			
PHYSICIAN'S NAME (Type) <u>G. W. Heenan</u>				Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 21 '56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith V. Lead</u>				ADDRESS <u>Md</u>		24a. REC'D BY REGISTRAR <u>Dec. 22, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Bowling Green</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

DEC 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13028
302
Reg. Dist. No.

13003				1			
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 03			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>46 N. Walnut St.</u>				d. STREET ADDRESS <u>46 N. Walnut St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Russell</u> Last <u>Wolfe</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>19</u> Year <u>19 56</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 4, 1890</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>railroad</u>		11. BIRTHPLACE (State or foreign country) <u>McConnellsburg, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? _____							
13. FATHER'S NAME <u>George Wolfe</u>				14. MOTHER'S MAIDEN NAME <u>Rhuey Ross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>705-10-4606</u>		17. INFORMANT <u>Mrs. Rhuey Cromer, Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Lobar pneumonia</u> DUE TO <u>Chronic Alcoholism</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>322.1</u> <u>Bronchial Asthma</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>None</u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	
				20f. (City or town) _____		(County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				DATE SIGNED <u>12-20-56</u>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12-21-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>Dec. 27, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Robert H. Bowers</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEC 26 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
c. LENGTH OF STAY IN 1b 9 days				d. STREET ADDRESS 145 South Prospect St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PEREGRINE Middle WROTH Last				4. DATE OF DEATH Month December Day 25 Year 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 17, 1882	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 10 Days 8 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician & Surgeon				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md/		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Peregrine Wroth				14. MOTHER'S MAIDEN NAME Mary Counselman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT E. T. Wroth		Address Saddle River, New Jersey	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis DUE TO (c) Arteriosclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH 10 days 10 days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 15, 1956 , to Dec 25, 1956 , that I last saw the deceased alive on Dec 24, 1956 , and that death occurred at 8 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. S. Stauffer				ADDRESS (Street, city or town, state) M.D. 170 W. Washington St., Hagerstown, Md			
PHYSICIAN'S NAME (Type) R. S. STAUFFER				DATE SIGNED 12/26/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/1956		22c. NAME OF CEMETERY OR CREMATORY I. U. Cemetery		22d. LOCATION (City, town, or county) (State) near Chambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Super-Rouzer Funeral Home R. Franklin Rouzer				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Dec 29, 1956	
				24b. REGISTRAR'S SIGNATURE Chas. H. Powers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		Male		45		1912		BALTIMORE, MARYLAND	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE AVE.		Carpenter		Heart Disease		Natural		BALTIMORE, MARYLAND	
DATE OF DEATH		TIME OF DEATH		HOURS		MINUTES		PLACE OF DEATH	
JAN 2 1957		10:15 AM		10		15		BALTIMORE, MARYLAND	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 2 1957		JAN 2 1957		JAN 2 1957		JAN 2 1957		JAN 2 1957	

BUREAU V. S.

JAN 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Well 13030

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

Item 8: G210 1-21-51

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 24 1/2 West Franklin St		d. STREET ADDRESS 24 1/2 West Franklin St	
3. NAME OF DECEASED (Type or print) First JOHN Middle HENRY Last YOUNG Sr		4. DATE OF DEATH Month December Day 26 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9 1905
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Letter Carrier		10b. KIND OF BUSINESS OR INDUSTRY U. S. Post Office	
11. BIRTHPLACE (State or foreign country) St James Wash. Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry K. Young		14. MOTHER'S MAIDEN NAME Margie Funk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Olive K. Young		Address 24 1/2 W. Franklin St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Hour none a. m. none p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/29/56	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR Dec 29, 1956		24b. REGISTRAR'S SIGNATURE Robert Bowers	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 2 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

307

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROWNSVILLE-RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROWNSVILLE RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BROWNSVILLE MD.</u>				d. STREET ADDRESS <u>BROWNSVILLE MD.</u>			
3. NAME OF DECEASED (Type or print) First <u>LEON</u> Middle <u>R</u> Last <u>YOURTEE</u>				4. DATE OF DEATH Month <u>DECEMBER-</u> Day <u>5</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY-31-1879</u>	
9. AGE (In years last birthday) <u>77-6-4</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTORNEY-GENERAL LAW PRACTICE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BROWNSVILLE WASH. CO. MD.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>DR. J. T. YOURTEE</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE BOTELER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. OLIVE A. YOURTEE BROWNSVILLE MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio-sclerosis</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>4/30</u> , 19 <u>56</u> , to <u>12/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/30</u> , 19 <u>56</u> , and that death occurred at <u>6 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>W.B. Carpenter</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>W.B. Carpenter</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 8, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. LUKES CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BROWNSVILLE WASH. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>BAST FUNERAL HOME BOONSBORO MD</u>				24a. REC'D BY REGISTRAR <u>Dec. 10/56</u>		24b. REGISTRAR'S SIGNATURE <u>Katherine Nagelhart</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 12 1956

RECEIVED